

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>Items 18-22a Fill in 110</div> <div>3-4-69 am</div> <div>11642</div> <div>21647</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>											
1. DECEASED NAME (Type or Print)						2a. DATE KNOWN OF DEATH			2b. HOUR		
<div>First</div> EARLE <div>Middle</div> LEON <div>Last</div> ABBOTT						<div>Month</div> 8 <div>Day</div> 11 <div>Year</div> 1968			<div>8:55 AM</div>		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years)	7. UNDER 1 YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
M	W	12-5-02	85 YRS	MONTHS	DAYS	HOURS	MIN	<div>Month</div> 8 <div>Day</div> 11 <div>Year</div> 1968			8:55 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
		U.S.A		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		MONTGOMERY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK			WASHINGTON SAN & HOSP.			BAKERY HELPER			BAKERY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MD.			MONT.			TAKOMA PK			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.					
<div>First</div> ABBOTT <div>Middle</div> <div>Last</div>			<div>First</div> NOT AVAILABLE <div>Middle</div> <div>Last</div>			577-16-9386					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			17. ADDRESS		
			577-16-9386			OLD RECORD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardiorespiratory failure,											
782.4 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Etiology undetermined											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
782.4											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
CAUSE OF DEATH		HOUR A.M. P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED					
EXAMINER'S NAME (Type)		BELDEN R. REAP		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Aug. 11, 1968					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Aug 14, 1968		Fort Lincoln Cemetery		Columbia Manor Md					
24. FUNERAL DIRECTOR		25a. ADDRESS		25b. RECORD BY REGISTRAR		25c. REGISTRAR'S SIGNATURE					
Arthur Walters		254 Carroll St NW		AUG 19 1968		J. Charles Judge					
Sakoma Funeral Home											

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.

4000

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Pages 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11642

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11648

1. DECEASED NAME (Type or Print) <b>CARL RICHARD ANTHONY</b>				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>8</b> Day <b>25</b> Year <b>1968</b>				2b. HOUR <b>M</b>	
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>11-25-15</b>	6. AGE (In years last birthday) <b>52</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>		2c. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>25</b> Year <b>1968</b>	
7a. BIRTHPLACE (State or foreign country) <b>So. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Wash. San. &amp; Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>Security Officer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Takoma P.</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>8700 Barron Street</b>	
14. FATHER'S NAME First <b>Carl</b> Middle <b>P.</b> Last <b>Anthony</b>				15. MOTHER'S MAIDEN NAME First <b>Plumie</b> Middle <b></b> Last <b>Ruff</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>237-16-3449</b>		17. INFORMANT <b>Wife</b>		ADDRESS <b>8700 Barron Str. Tak. Pk., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Acute Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Heart Disease</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b></b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>									
19a. DATE OF OPERATION <b>4-29-68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Belden R. Reap</b>		EXAMINER'S NAME (Type) <b>Belden R. Reap, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-29-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Huattville Prince Georges Md.</b>		23e. DATE SIGNED <b>Aug. 25, 1968</b>	
25a. REC'D BY REGISTRAR <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S., Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 30 1968</b>			

THE UNIVERSITY OF CHICAGO

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### Regulation

1978-1979: 20

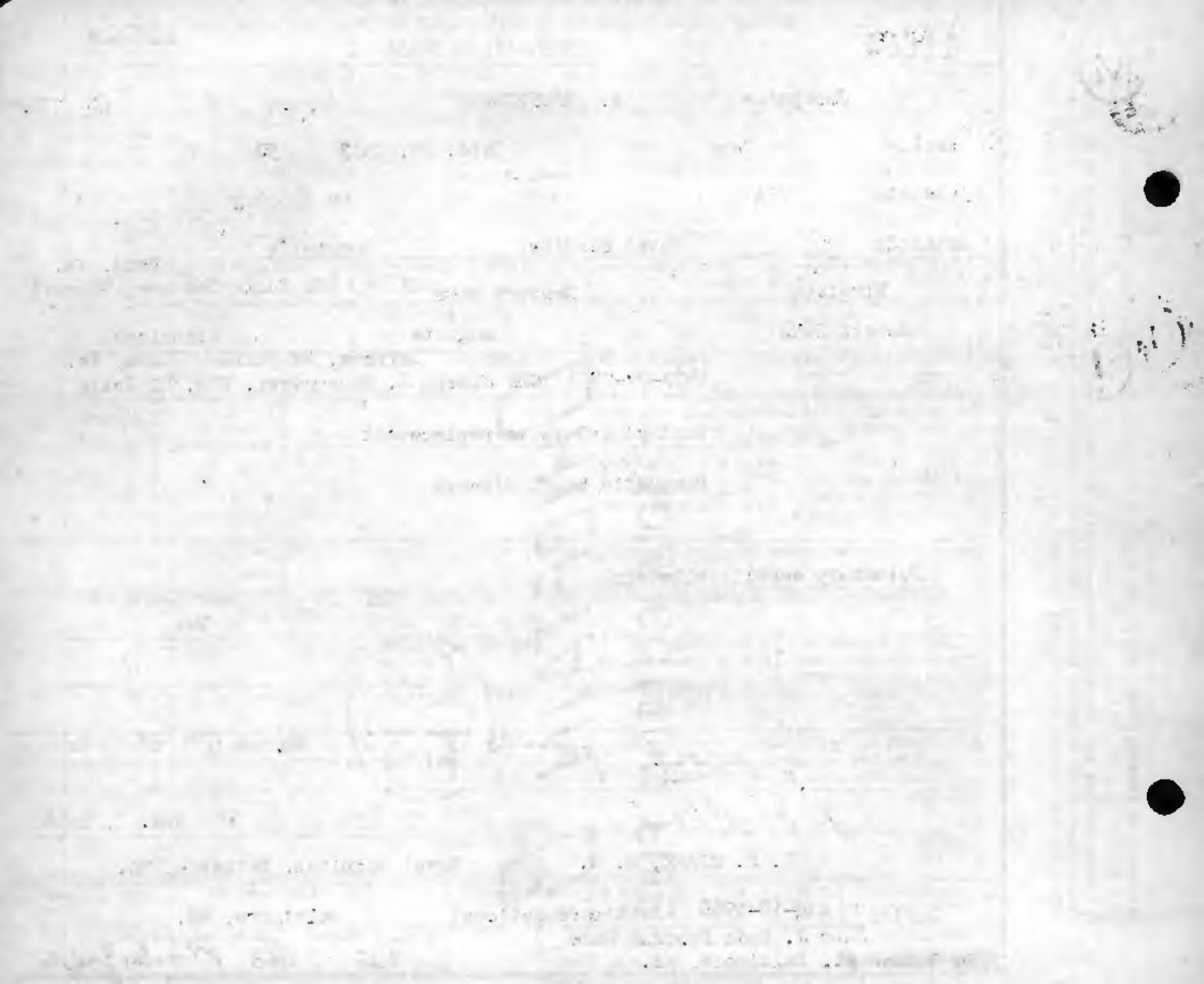
11643

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Josephine				A. ANUSZEWSKI	August 6 1968		730 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Female	Cauc		Sept. 17, 1917		50		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Minnesota		USA				Montgomery Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda		Naval Hospital		Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Virginia				Newport News				News, Va. 22 Julia Terrace, Newport
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
Robert Sula					Augusta			Glenzinski
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Terrace, Newport Address News, Va.		
no		477-07-7231		CWO Joseph L. Anuszewski, USA,		22 Julia		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post mitral valve replacement</u> <u>3940</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rheumatic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>410x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pulmonary emboli; bilateral</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>July 15</u> , 19 <u>68</u> , to <u>August 6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>August 6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
<u>R. E. Clark</u>						Aug. 7, 1968		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
R. E. CLARK, M. D.		Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Aug-12-1968		Baltimore National		Baltimore, Md.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
John J. Duda Funeral Home		DATE AUG 12 1968		<u>Charles Judge</u>				
2829 Hudson St., Baltimore, Md.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill out items 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11644

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11650

1. DECEASED NAME (Type or Print)		First Middle Last		2a. DATE KNOWN OF DEATH		ESTIMATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
MIRIAM A. Arnold				Aug 8 1968				P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Fe.	W.	8-13-11	56 YRS.					Aug Day 11 Year 1968 5:15 P.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
OHIO		U.S.A.				Montgomery		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		5100 Dorset Ave.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Montgomery		Bethesda				5100 Dorset Ave. apt 101	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Clayton		Eyster		No		214-36-3807		Son Francis Arnold III	
								ADDRESS as Item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination									Sudden
DUE TO, OR AS A CONSEQUENCE OF (b) Gastro Hemorrhage									Sudden
DUE TO, OR AS A CONSEQUENCE OF (c) Acute & Chronic Alcoholism									Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
303.2									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19 P.M.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Aug 11, 1968			
JOHN G. BALL			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		8-14-68		Gettysburg Natl Cem.		Gettysburg, Penna.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY, Bethesda, Maryland				DATE AUG 15 1968		J Charles Judge			

6

EDWARD G. COLLIER



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
11645											
CERTIFICATE OF DEATH											
11651											
1. DECEASED NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR A		
First Middle Last Douglas Eugene Baker						Month Day Year August 17 1968			7:30 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		3 January 1949		19 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Virginia		USA				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		The Clinical Center, NIH				Student		None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Virginia		Frederick		Whitacre				(None)			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Alonzo O. Baker				Josephine Baker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No				16b. SOCIAL SECURITY NO.		17. INFORMATION					
				232-78-0997		The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Metastatic Choriocarcinoma to Lungs											
1865x DUE TO, OR AS A CONSEQUENCE OF											
(b) Metastatic Choriocarcinoma from Left Testicle											
Approx 18mo											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
178x											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (this hospital) attended the deceased from 31 July 1968, to 17 August 1968, that (we) last saw the deceased alive on 17 August 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
John A. Grant, M.D.						17 August 1968					
22d. PHYSICIAN'S NAME (Type) John A. Grant, M. D.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		8-20-68		Woodlawn Cemetery		Whitacre, Frederick, Va					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Giffin Funeral Home, Capen Bridge, W.Va.						AUG 20 1968		Charles Judge			

THE UNITED STATES OF AMERICA

REPORT

OF THE

COMMISSIONER

TO

THE HOUSE OF REPRESENTATIVES

AND

THE SENATE

IN

1890

AND

FOR THE YEAR 1889

AND THE YEAR 1890

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and military event, within 72 hours after death.

11646

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11652

1 DECEASED-NAME (Type or print) <b>Homer Reid BAKER</b>			2a. DATE OF DEATH Month <b>8</b> Day <b>19</b> Year <b>68</b>			2b. HOUR <b>5:00P</b>			
3 SEX <b>Male</b>		4 RACE <b>Cauc</b>		5. DATE OF BIRTH <b>29 Oct 1904</b>		6. AGE (in years lost birthday) <b>63</b> YRS.		7. UNDER 24 HRS MONTHS YEAR DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
3a. USUAL RESIDENCE (Where deceased admission) STATE <b>Virginia</b>		3b. COUNTY <b>Alexandria</b>		3c. CITY OR TOWN <b>Alexandria</b>		3d. HOME CITY (If not YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e. STREET AND NUMBER <b>6218 Tally Ho Lane</b>	
4. FATHER'S NAME First <b>Jesse Alexander Baker</b> Middle <b></b> Last <b></b>				5. MOTHER'S M.A.D.E.N. NAME First <b>Lillian M. Bass</b> Middle <b></b> Last <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/> <b>WWII</b> dates of service, <b></b>		6b. SOCIAL SECURITY NO <b>577 54 4251</b>		7. INFORMANT <b>Alexandria, Va</b> Address <b>Mrs. Frances G. Baker, 6218 Tally Ho Lane</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the Lung</b> <b>1051</b> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b></b> DUE TO OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Indeter.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b></b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18,)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (A. HOME B. ARMED SERVICE C. FACTORY OFFICE BUILDING, ETC.)		22. LOCATION Street or R.F.D. No City or town County State					
22a. I certify that (X) (this hospital) attended the deceased from <b>Aug. 10</b> , 19 <b>68</b> to <b>Aug. 19</b> , 19 <b>68</b> , that (X) we lost saw the deceased as on <b>Aug. 19</b> , 19 <b>68</b> and that (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John W. Brackett, Jr. MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Aug. 19, 1968</b>			
22d. PHYSICIAN'S NAME Type <b>John W. BRACKETT, JR., MD.</b>				22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL (CREMATION BY WHOM) <b>Burial</b>		23b. DATE <b>8/22/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Virginia</b>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>Dominic Memorial Chapel</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 4 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11649

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11655

CERTIFICATE OF DEATH

DECEASED NAME (Type or print) <i>Milton Herman Barmettler</i>			2a. DATE OF DEATH Month <i>Aug</i> Day <i>2</i> Year <i>1968</i>			2b. HOUR <i>2:30 AM</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>7/15/1902</i>		6. AGE (in years last birthday) <i>66</i> YRS		7. UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Nebraska</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Salvecher</i>		2c. S.I.A. OCCUPATION (Kind of work done during most of working life even if retired.) <i>Sales</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Cash Register</i>			
3a. U.S.A. RESIDENCE Where deceased lived + institution Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Bethesda</i>		3c. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <i>4977 Battery Lane</i>	
14. FATHER'S NAME First <i>Herbert</i> Middle <i>Barmettler</i> Last <i>Barmettler</i>			15. MOTHER'S MAIDEN NAME First <i>Sara</i> Middle <i>McLure</i> Last <i>McLure</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give unit or dates of service)		16b. SOC. SEC. NO. <i>275-05-7575</i>		17. INFORMANT <i>Wife</i> <i>Joyce W. Barmettler</i>		Address Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma Right Lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (3. VENTILATOR PART 1(a)) <i>① Rheumatic Heart Disease - Aortic Stenosis</i> <i>② Pulmonary emphysema</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>9</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1966</i> to <i>8/2</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8/1</i> , 19 <i>68</i> , and that n (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Blaine Fitzgerald</i> M.D.		22c. PHYSICIAN'S NAME (Type) <i>J. Blaine Fitzgerald, M.D.</i>		22d. ADDRESS <i>8218 Wisconsin Avenue Bethesda</i>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED <i>8/2/68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>Aug. 5, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Cockeysville, Maryland</i>			
24. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson</i>		25a. ADDRESS <i>1050 York Road Towson, Maryland 21204</i>		25b. REC'D BY REGISTRAR <i>AUG 5 1968</i>		25c. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
11648																							
CERTIFICATE OF DEATH																							
1. DECEASED NAME (Type or print)			First EDITH			Middle BAIREN			Last AUG			2a. DATE OF DEATH Month 8 <sup>th</sup> Day Year 68			2b. HOUR 7:45 P.M.								
3. SEX FEMALE			4. RACE white			5. DATE OF BIRTH 12-24-20			6. AGE (In years last birthday) 47 YRS.			7. UNDER YEAR MONTHS DAYS HOURS MIN.			8. UNDER 24 HRS MONTHS DAYS HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) DC			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY			10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission STATE Maryland			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 1703 East-West Highway			14. FATHER'S NAME First Middle Last Benjamin Warsaw			15. MOTHER'S MAIDEN NAME First Middle Last Selma Cohen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give no. or date of service) 579-34-9515			17. INFORMANT HOSP RECORD.			18. ADDRESS			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a), 174X DUE TO, OR AS A CONSEQUENCE OF (b) SECONDARY BREAST CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)																	
22a. INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			22c. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from 1965, 19 to 8-5-1968 that (I) (we) last saw the deceased alive on 8-5-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d.) (did not) view the body after death.																							
22b. SIGNATURE Robert Kramer MD			22c. DATE SIGNED 8-5-68			22d. PHYSICIAN'S NAME (Type) ROBERT KRAMER MD			22e. ADDRESS 8484 16 <sup>th</sup> ST. S.S. Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 8/7/68			23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Mem. Park			23d. LOCATION (City or Town, County) State Hyattsville Md.														
24. FUNERAL DIRECTOR Bernard Danzansky & Sons, Washington, D.C.			25a. REC'D BY REGISTRAR DATE AUG 9 1968			25b. REGISTRAR'S SIGNATURE Charles Judge																	



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TU FINE DIRECTOR:** After this certificate has been signed on this page, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11650

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11656

**CERTIFICATE OF DEATH**

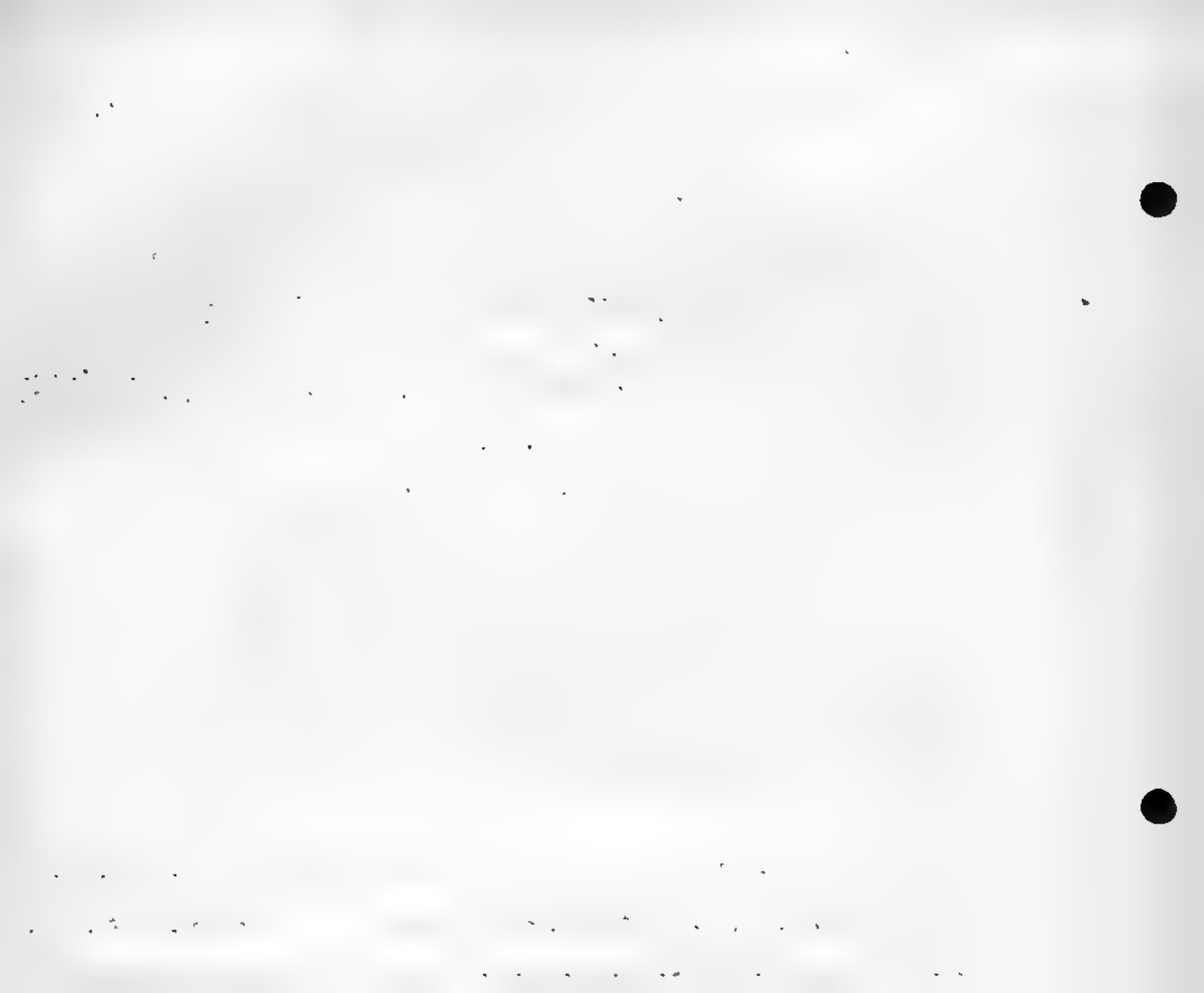
1. DECEASED NAME (Type or print) First Middle Last <b>Thomas L. BARNETT</b>			2a. DATE OF DEATH Month Day Year <b>August 19 1968</b>			2b. HOUR <b>1200</b>					
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Feb. 11, 1904</b>		6. AGE (in years last birthday) <b>64</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>			Md		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Naval Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		12b. KIND OF BUSINESS OR INDUSTRY					
3a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>D. C.</b>		3b. COUNTY <b>136</b>		3c. CITY OR TOWN <b>Washington</b>		3d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>1354 W Street, S.E. Apt. /</b>		2	
4. FATHER'S NAME First Middle Last <b>Richard Barnett</b>				5. MOTHER'S MAIDEN NAME First Middle Last <b>Josephine Golden</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes</b>		16b. SOCIAL SECURITY NO		17. INFORMANT <b>Mr. Leroy G. Barnett</b>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Glioblastoma multiforme</b> <b>17-17</b> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>193</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (A HOME FARM, STREET, FACTORY) OFFICE BUILDING ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (A) (this hospital) attended the deceased from <b>July 24 1968</b> to <b>Aug. 19 1968</b> , that (B) (we) last saw the deceased alive on <b>Aug. 19 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John Paul Wiggner</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>20 August 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>John Paul Wiggner, M.D.</b>				22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-23-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>					
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm</b>		ADDRESS <b>Suitland Road</b>		25a. REC'D BY REGISTRAR <b>AUG 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
MARIA			BATTAGLINI			Aug. 27 1968			9A M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER 1 YEAR		8 UNDER 24 HRS	
female		white		2/6/1900		68 YRS.		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED			9 COUNTY OF DEATH		
ITALY			U.S.A.			NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery		
10 CITY OR TOWN OF DEATH			NAME OF HOSPITAL OR INSTITUTION (not in hospital give street address)			12a USUAL OCCUPATION Kind of work done during most of working life even if retired.			12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hospital			housewife			own home		
13a USUAL RESIDENCE (Where deceased lived if not in hospital admission) STATE			13b COUNTY			13c INSIDE CITY LIMITS?			13d STREET AND NUMBER		
Md.			Montgomery			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			811 Whittington Terrace		
4 FATHER'S NAME			5 MOTHER'S M.A.D.E.N NAME			15 INFORMANT			16 ADDRESS		
CIRIO			BARSANTI			Celestina			BINI		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			18 ADDRESS		
No			577-46-4068			Michela Battaglini			811 Whittington Terrace		
18 CAUSE OF DEATH Enter only one cause per line for a), b) and c).											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction + Cerebral infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive + Intracerebral Cardiovascular + Cerebrovascular Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disease</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)											
MEDICAL CERTIFICATION											
9a DATE OF OPERATION			9b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
[ ] CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year								
21d INJURY OCCURRED			21e PLACE OF INJURY (A HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>											
22a I certify that (I) (th s hospital) attended the deceased from <u>Aug 17, 1968</u> , to <u>Aug 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b SIGNATURE						ATTENDING PHYSICIAN			22c DATE SIGNED		
Bernard A. Heckman, M.D. DEGREE						<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
22d PHYSICIAN'S NAME (Type) Bernard A. Heckman						22e ADDRESS					
						8107 Eastern Avenue, Sil. Spr., Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			Aug. 30, 1968			Gate of Heaven Cemetery			Silver Spr. Mont. Md.		
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
John Carter						DATE			AUG 30 1968		
H.E. Pumphrey, Inc. 8434 Ga Ave. Sil. Spr. Md.									J. Charles Jones		





TO HOSPITAL OR ATTENDING PHYSICIAN- The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR- After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Obituary - Medical Examiner - Baltimore

11652

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11658

1. DECEASED NAME (Type or print) <b>Carl</b>		First <b>J.</b>	Middle <b>J.</b>	Last <b>Bausch</b>	2a. DATE OF DEATH Month <b>8</b> Day <b>6</b> Year <b>68</b>		2b. HOUR <b>6:32 P</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>4/9/1894</b>		6. AGE in years (last birthday) <b>74</b> YRS		7. UNDER 24 HRS MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN
7a. BIRTHPLACE State or foreign country <b>Piqua Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hosp</b>		12a. USUAL OCCUPATION Kind of work done during most of working life, even if retired. <b>Molder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>14000 London Lane</b>
14. FATHER'S NAME First <b>Christian</b>		Middle <b>Bausch</b>		Last <b>Bausch</b>		15. MOTHER'S M.A.D.E.N NAME First <b>Rosa</b>		Middle <b>Reichart</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown? <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579-30-8010</b>		17. INFORMANT Address <b>Mrs Marguerite L. Bausch-Item # 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Carcinoma lung, primary</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>Carcinoma lung, primary</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b> <b>10 mos.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1621</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that ( ) (this hospital) attended the deceased from <b>July 3, 1968</b> , to <b>Aug 6, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Aug 1, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>A.W. Smith M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/6/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>A.W. SMITH</b>		22e. ADDRESS <b>13018 GEORGIA AVE WHEATON, MD 20906</b>						
23a. BURIAL (CREMATION, REMOVAL, SPOULV)		23b. DATE <b>8/9/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>		
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 8, 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>		



**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A 5M2 15  
OM REV 216

<div style="display: flex; justify-content: space-between;"> <span>11653</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span style="text-align: right;">TOP 59</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
1 DECEASED NAME (Type or Print) <span style="font-size: 1.2em;">First Middle Last</span> <b>Harold Townsend BENT Jr.</b>						2a DATE KNOWN OF DEATH <input type="checkbox"/> EST <input checked="" type="checkbox"/> MAT D <b>Aug 9 1968</b>			2b MONTH DAY YEAR <b>12 25 1968</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>Dec. 6, 1920</b>	6 AGE in years (as birthday) <b>47 YRS</b>	7 IF 24 HRS YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD <b>Aug 9 1968</b>			2d HOUR <b>2:30 PM</b>		
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CT ZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>			Md		
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		1 NAME OF HOSPITAL OR NSTITUTION (if not in hospital give street address) <b>Suburban</b>				12a USAL OCCUPATION (Kind at work done during most of working life even if retired) <b>Electrician Engineer Gov.</b>			12b KIND OF BUSINESS OR INDUSTRY		
3a USAL RES. DENCE (Where deceased lived, institution, residence, etc.) admission, STATE <b>Virginia</b>		3b COUNTY <b>Arlington</b>		13 CITY OR TOWN <b>Arlington</b>		3c INSIDE <input checked="" type="checkbox"/> OUTSIDE <input type="checkbox"/>		13a STREET AND NUMBER <b>923 - 20th Street S</b>			
4 FATHER'S NAME <span style="font-size: 1.2em;">First Middle Last</span> <b>Harold T. Bent</b>				15 MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">First Middle Last</span> <b>Elizabeth Smith</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>Yes</b>		16b SOCIAL SECURITY NO <b>WWH</b>		17 INFORMANT <b>Wife (Elizabeth Bent)</b>				ADDRESS <b>2204 Troglus Lane Falls Church, Va</b>			
B CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Transection spinal cord, cervical</b> <b>516 C</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>fracture, vertebrae, cervical</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>automobile accident</b>										APPROXIMATE IN TERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDITION GIVEN IN PART 1a <b>22</b>											
19a DATE OF OPERATION				9b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 A. TOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
2a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		2b TIME OF INJURY Month, Day Year <b>12 PM Aug 9 1968</b>		2c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 8) <b>Lost control of car on H. road. turned over</b>							
2d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		2e PLACE OF INJURY (A home farm street factory office building, etc.) <b>Highway</b>		2f LOCATION Street or R.F.D. NO. <b>Route 70s at 495</b>		City or Town <b>Bethesda</b>		County <b>Montgomery</b>		State <b>Md</b>	
22a I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <span style="font-size: 1.5em;">John H. Ball</span>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <b>Aug 9, 1968</b>			
EXAMINER'S NAME (Type) <b>John H. Ball</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a B R A (REMAI) ON REMOVAL Specify <b>Cremation</b>		23b DATE <b>8-9-68</b>		23 NAME OF CEMEYERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d OCATION (City or Town) (County, State) <b>Switzland Md</b>			
24 FUNERAL DIRECTOR <b>Murphy Funeral Home</b>				ADDRESS <b>Arlington, Va.</b>				25a REC'D BY REGISTRAR <b>AUG 15 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

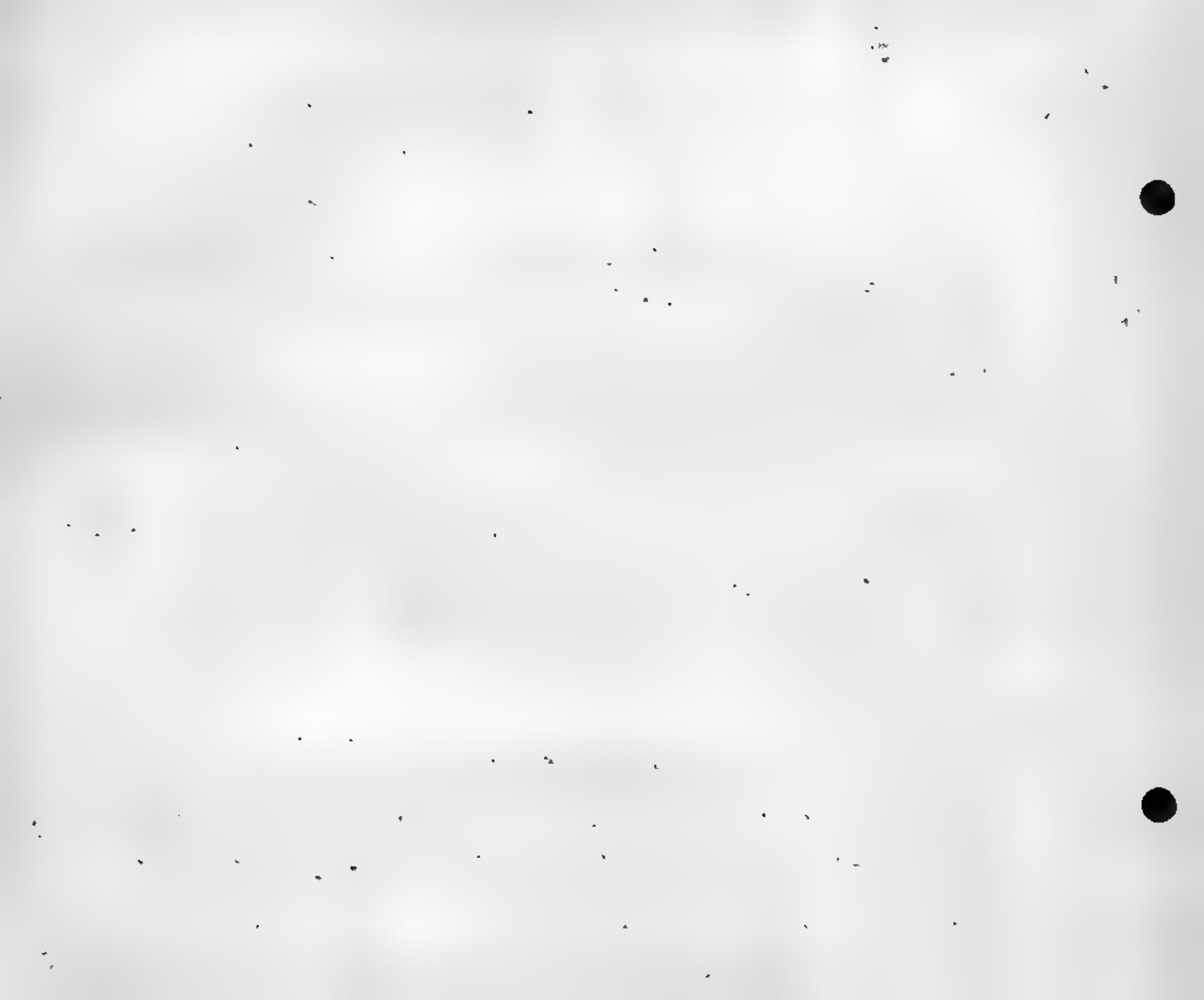
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. When possible, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11654

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

11654

DECEASED NAME (Type or print)		First	Middle	Last	20. DATE OF DEATH		2b. HOUR		
VICTOR -				BERTE	Aug 2 1968		8:30pm		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
male	white		April 6, 1886		82 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Italy		USA		Montgomery		Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION, if not in hospital give street address		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. NO. OF BUSINESS OR INDUSTRY			
Kensington		3406 - Thimble Rd		nurse		1			
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Ind.		Mont.		Kensington		YES		As above	
4. FATHER'S NAME First Middle Last				5. MOTHER'S MAIDEN NAME First Middle Last					
Unknown				Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give year or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
				066-05-3608a		Virta A Bute, 3814 Oakland Park			
18. CAUSE OF DEATH Enter on any one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO OR AS A CONSEQUENCE OF <u>Cerebral Arteriosclerosis</u> (b) <u>Generalized Arteriosclerosis</u> DUE TO OR AS A CONSEQUENCE OF <u>Arteriosclerotic Heart Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1, (a) <u>Arteriosclerotic Heart Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 year 8 years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 9		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (A HOME, APART, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <u>May 1967</u> to <u>Aug 2, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Harry N. Carlton, MD</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>Aug 2, 1968</u>					
22d. PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>				22e. ADDRESS <u>8811 Colver Rd, Silver Spring, Md</u>					
23a. BURIAL, CREMATION, REMOVAL, SPECIALLY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) State			
Burial - Transit		8/6/68		Holy Cross		Brooklyn, New York			
24. FUNERAL DIRECTOR <u>Lyson Wheeler</u> ADDRESS <u>Funeral Home-1331 Rockville Pike Rockville, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11655

1968

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It may be delayed in any day is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN Month Day Year				2b. HOUR M			
William H.						Besset		Aug 24 1968				5:15 PM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	7. UNDER YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD Month Day Year				2d. HOUR M		
male	white	3/03/13		54 YRS					Aug 24 1968				5:15 PM		
7b. BIRTHPLACE (State or foreign country)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH									
Md.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR (if not in hospital give street address)		12a. USUAL OCCUPATION (kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY									
Bethesda		St. Elizabeth's		Teacher		High School									
13a. A.A. RESIDENCE (Where deceased lived if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. HOUSE CITY		13e. STREET AND NUMBER							
Md.		city		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		2034 - Third St. N.W.							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S M.A.DEN NAME		First		Middle		Last	
William H.						Besset		Mary Ann						Walter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
no		217 019630		Edith M. Besset		Baltimore									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Old and Acute Myocardial infarction, extensive												APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH			
4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary thrombosis, old and acute												sudden			
DUE TO, OR AS A CONSEQUENCE OF (c) Advanced coronary arteriosclerosis												years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
+2.1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXT REMA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18)							
				19											
22. IN INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				22a. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				22b. LOCATION Street or R.F.D. No. City or Town County State							
22c. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		EXAMINER'S NAME Type		22d. DATE SIGNED		22e. REGISTRAR'S SIGNATURE									
John B. Bell				Aug 25 1968		Charles Judge									
23a. BURIAL PERMIT NO.		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town County State)									
Burial		8-28-68		Merdownidge		Howard Co. Md.									
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Burque Funeral Home Balto Md				AUG 29 1968				Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11656

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1968

1. DECEASED NAME (Type or print) <i>Emily S Bienia</i>		2a. DATE OF DEATH Month <i>8</i> Day <i>6</i> Year <i>68</i>		2b. HOUR <i>6:45 A M</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>March 4, 1916</i>	6. AGE (in years last birthday) <i>52</i> YRS.	7. UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Cleveland, Ohio</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION, if not in hospital give street address <i>1109 Tanley Road</i>	12. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Housewife</i>	13. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>1109 Tanley Road</i>
4. FATHER'S NAME First Middle Last <i>Joseph Starcherak</i>	5. MOTHER'S MAIDEN NAME First Middle Last <i>Louise Guzik</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes. No. or unknown, <i>No</i> If yes give war or dates of service:	6b. SOCIAL SECURITY NO. <i>270-09-5422</i>	17. INFORMANT <i>(Husband) Walter Bienia</i>	Address <i>Silver Spring 1109 Tanley Road</i>	
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <i>Osteogenic Sarcoma with</i> <i>1709</i> DUE TO, OR AS A CONSEQUENCE OF (b): <i>Pulmonary Metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c): Contributing factors (any which gave rise to immediate cause (a), stating the underlying cause last):				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>22 mos</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 19 66</i> to <i>Aug 6 1968</i> that (I) (we) lost the deceased alive on <i>Aug 5 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (a) (d) (did not) view the body after death				
22b. SIGNATURE <i>Bernard A Fitzgerald MD</i>		22c. DATE SIGNED <i>8-6-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>BERNARD A FITZGERALD</i>		22e. ADDRESS <i>217 UNIV BLVD E SILVER SPRING, MD</i>		
23a. BURIAL, CREMATION, REMOVAL, See (4)	23b. DATE <i>Aug 8, 1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>	23d. LOCATION (City or Town, County, State) <i>Silver Spring, Mtgo. Md.</i>	
24. FUNERAL DIRECTOR <i>Walter E. Purphrey, Inc. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 9 1968</i>		25b. REGISTRAR SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial or cremation, or removal, and in any event within 72 hours after death.

11657

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Louis Theodore Biggs</b>			2a. DATE OF DEATH Month <b>Aug</b> Day <b>31</b> Year <b>1968</b>		2b. HOUR <b>11:35 PM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>March 7, 1906</b>		6 AGE in years (last birthday) <b>62</b> YRS	7 UNDER 1 YEAR MONTHS <b>11</b> DAYS <b>24</b> HOURS <b>11</b> MIN.
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sanitarium</b>		2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Banker</b>		2b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, Resident before admission) STATE <b>Md</b>	13b. COUNTY <b>Montgomery</b>	3c. CITY OR TOWN <b>Silver Spring</b>	3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3e. STREET AND NUMBER <b>9507 - Second Ave</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>W.</b> Last <b>Biggs</b>		15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>Hornig</b> Last <b></b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or date of service)		16b. SOCIAL SECURITY NO <b>577-22-1912</b>	17 INFORMANT Address <b>Mrs. Maggie C. Biggs Silver Spring, Md.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>Coronary Arteriosclerosis</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>4201</b> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>1 1/2 yrs</b>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes, Chronic Renal Disease, Emphysema</b>					
19a. DATE OF OPERATION <b>None</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTROLLING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR <b>19</b> P.M. Month <b>Aug</b> Day <b>31</b> Year <b>1968</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 23 1968</b> to <b>Aug 31 1968</b> that (I) (we) last saw the deceased alive on <b>Aug 31 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <b>John Lawrence Avery, M.D.</b>		22c. DATE SIGNED <b>Aug 31, 1968</b>	22d. PHYSICIAN'S NAME (Type) <b>JOHN LAWRENCE AVERY</b>		
22e. ADDRESS <b>10620 Georgia Ave., Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>9/4/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, P.G., MD.</b>		
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SONS, 5130 WISCONSIN AVE. N.W. WASHINGTON, D.C. 20016</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1968</b>	25b. REGISTRAR'S SIGNATURE <b>John Lawrence Avery</b>		

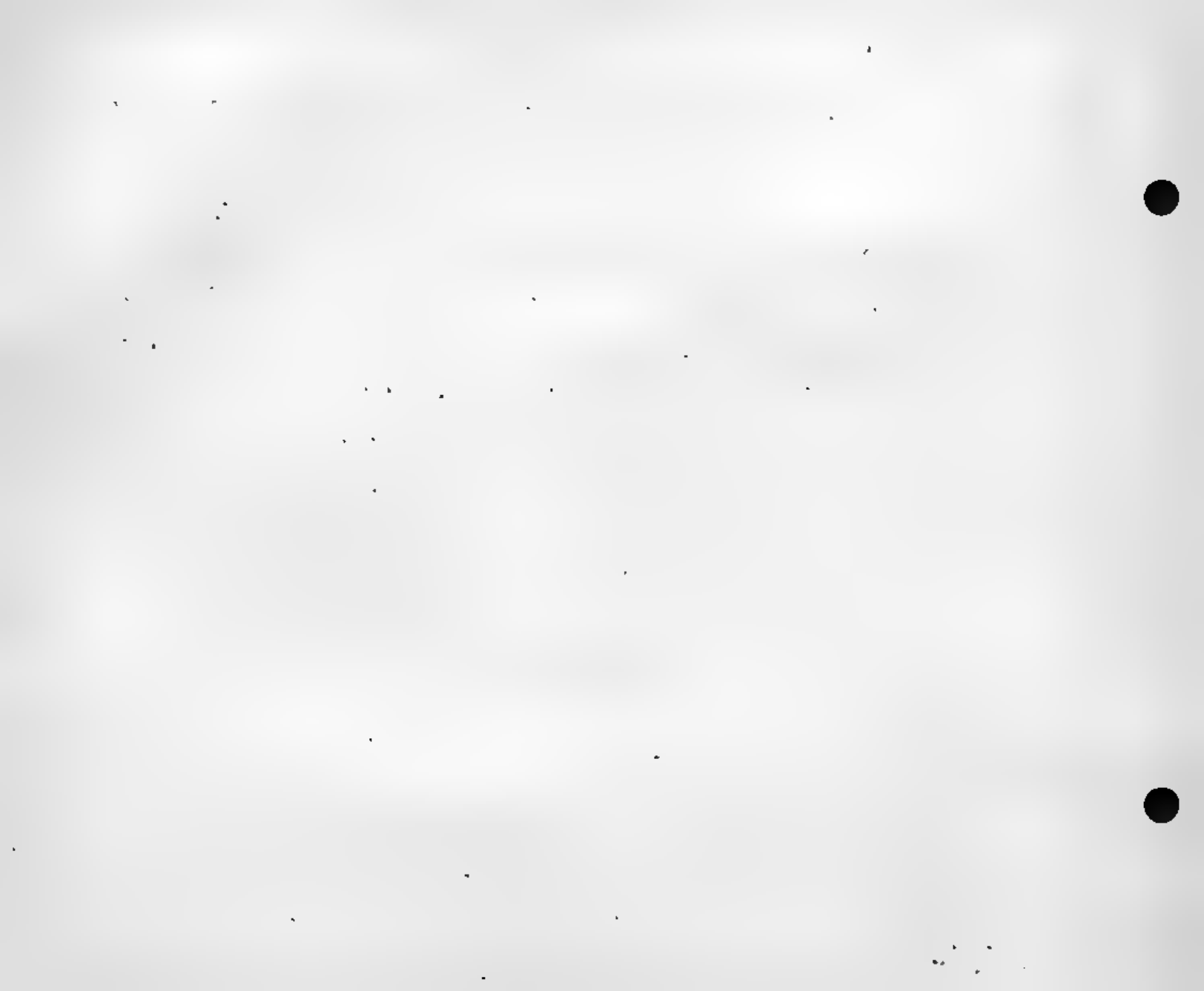




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1, 2, and 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11653										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11664				
CERTIFICATE OF DEATH																								
1 DECEASED NAME (Type or print)					First Middle Last					2a DATE OF DEATH Month Day Year					2b HOUR									
Trygve					(NONE)					Bjertnes					August 26, 1968					4 A. M.				
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (in years last birthday)			7 IF UNDER 1 YEAR			8 IF UNDER 24 HRS									
Male			White			November 7, 1889			78 YRS			MONTHS			DAYS									
7a BIRTHPLACE (State or foreign country)					7b CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH									
Norway					America										Montgomery									
10 CITY OR TOWN OF DEATH					NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)					11a USUAL OCCUPATION (Kind of work done during most of work life, or even if retired)					11b NO. OF BUSINESS OR INDUSTRY									
Takoma Park					Washington Sanitarium					Naval Medical Center														
12a USUAL RESIDENCE (Where deceased lived, or institution residence before admission) STATE					12b COUNTY					12c CITY OR TOWN					12d STREET AND NUMBER									
Maryland					Montgomery					Takoma Park					324 Boyd Avenue									
4 FATHER'S NAME First Middle Last					5 MOTHER'S M A DEN NAME First Middle Last																			
Bjertnes					Helen					Anderson														
6a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					6b SOCIAL SECURITY NO					17 INFORMANT					Address									
yes					Army-WWII					577-42-2179					Patient's chart									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>coronary artery disease</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>months</u> <u>years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u> <u>Severe Parkinson's</u>																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)					21f. LOCATION Street or R.F.D. No City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>8-17</u> 19 <u>68</u> to <u>8-26</u> 19 <u>68</u> that (I) (we) lost saw the deceased alive on <u>8-26</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE <u>John L Ford M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED <u>8/26/68</u>														
22d. PHYSICIAN'S NAME (Type) <u>JOHN L. FORD MD</u>										22e. ADDRESS <u>631 UNIVERSITY BLVD SILVER SPRING MD</u>														
23a. BURIAL CREMATION (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					Aug 29 1968					Baltimore National					Baltimore Md									
24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>254 Carroll St W.</u>					25a. REC'D BY REGISTRAR <u>AUG 28 1968</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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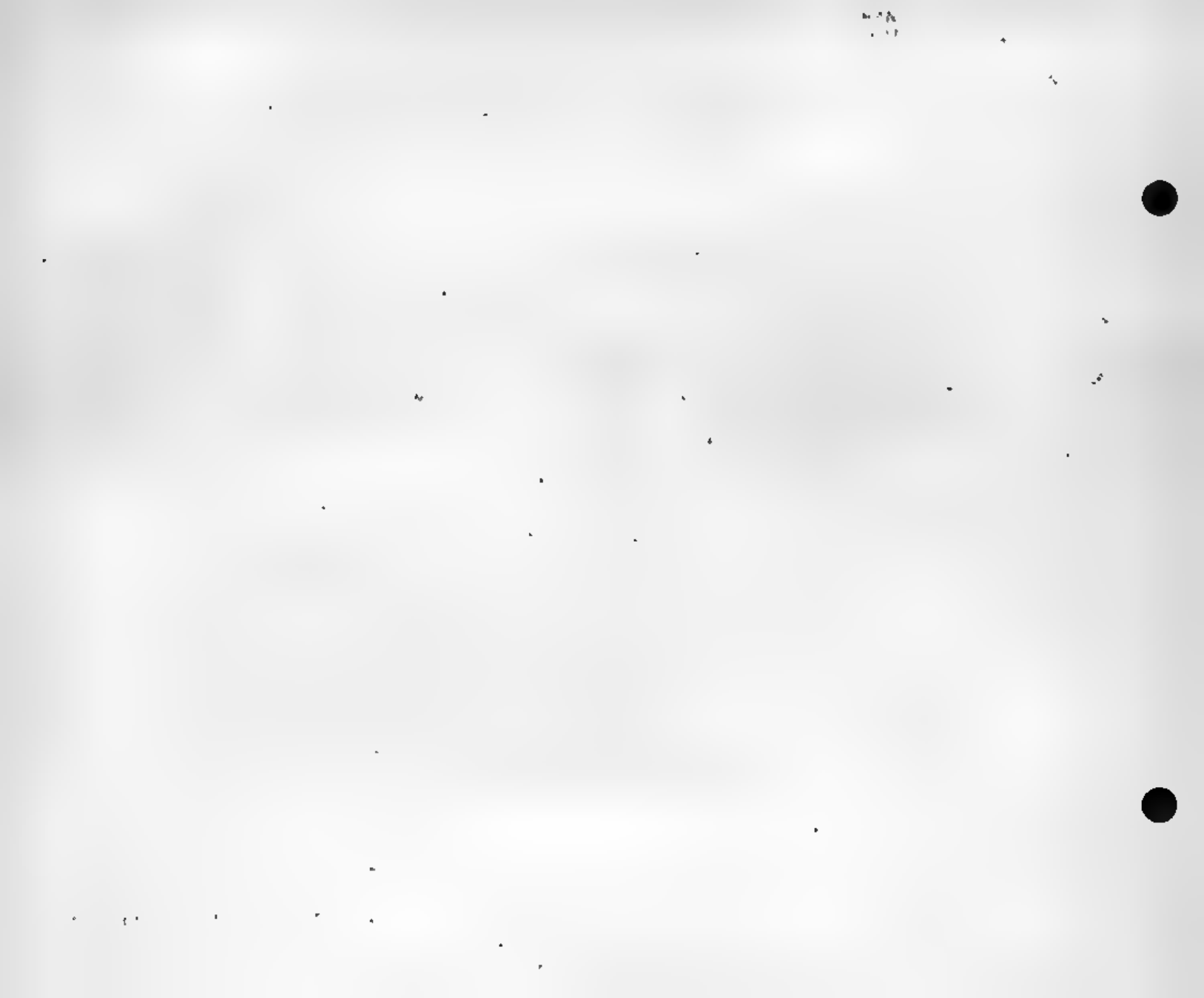
VA AIS (4)  
304a REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

11659

11665

1 DECEASED NAME (Type or print) <b>Charles Theodore Bonawitz</b>			2a. DATE OF DEATH Month <b>8</b> Day <b>27</b> Year <b>68</b>			2b. HOUR <b>2:30</b> A.M.			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>1-28-05</b>		6 AGE (In years last birthday) <b>63</b> YRS		7 IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN	
7a BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b> Md			
D CITY OR TOWN OF DEATH <b>Takoma Park</b>		11 NAME OF HOSPITAL OR INSTITUTION (Not in hospital give street address) <b>Wash. San. &amp; Hsp.</b>		2a USUAL OCCUPATION Kind of work done during most of working life even if retired <b>Foreman</b>		12b KIND OF BUSINESS OR INDUSTRY <b>D. of Hgwys</b>			
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>HOWARD</b>		13c CITY OR TOWN <b>Simpsonville</b>		13d RESIDENTIAL ADDRESS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>12 Seneca Drive</b>	
14 FATHER'S NAME First Middle Last <b>John Bonawitz</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Emma Wolff</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (all unknown) (If yes give year or dates of service) <b>No</b>		16b SOCIAL SECURITY NO. <b>179-18-2334</b>		7 INFORMANT <b>Pt. Record</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>101X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pancytopenia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hodgkin's Disease Class 4</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home farm, street, factory, office, building, etc.)		21f LOCATION Street or RFD No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <b>8/18/68</b> to <b>8/27/68</b> , that (I) (we) last saw the deceased alive on <b>8/27/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d) (did not) view the body after death									
22b SIGNATURE <b>Alan R. Gair MD</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>8/27/68</b>			
22d PHYSICIAN'S NAME (Type) <b>Alan R. Gair MD</b>		22e ADDRESS <b>3118 Craycroft Rd Baltimore, Md</b>							
23a BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b DATE <b>8/30/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Schuylkill Memorial Pk.</b>		23d LOCATION (City or Town) (County) (State) <b>Schuylkill Haven Pa.</b>			
24 FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>				ADDRESS <b>331 Rock. Pike</b>		RECD BY REGISTRAR <b>AUG 28 1968</b>		25b SIGNATURE OF REGISTRAR <b>[Signature]</b>	



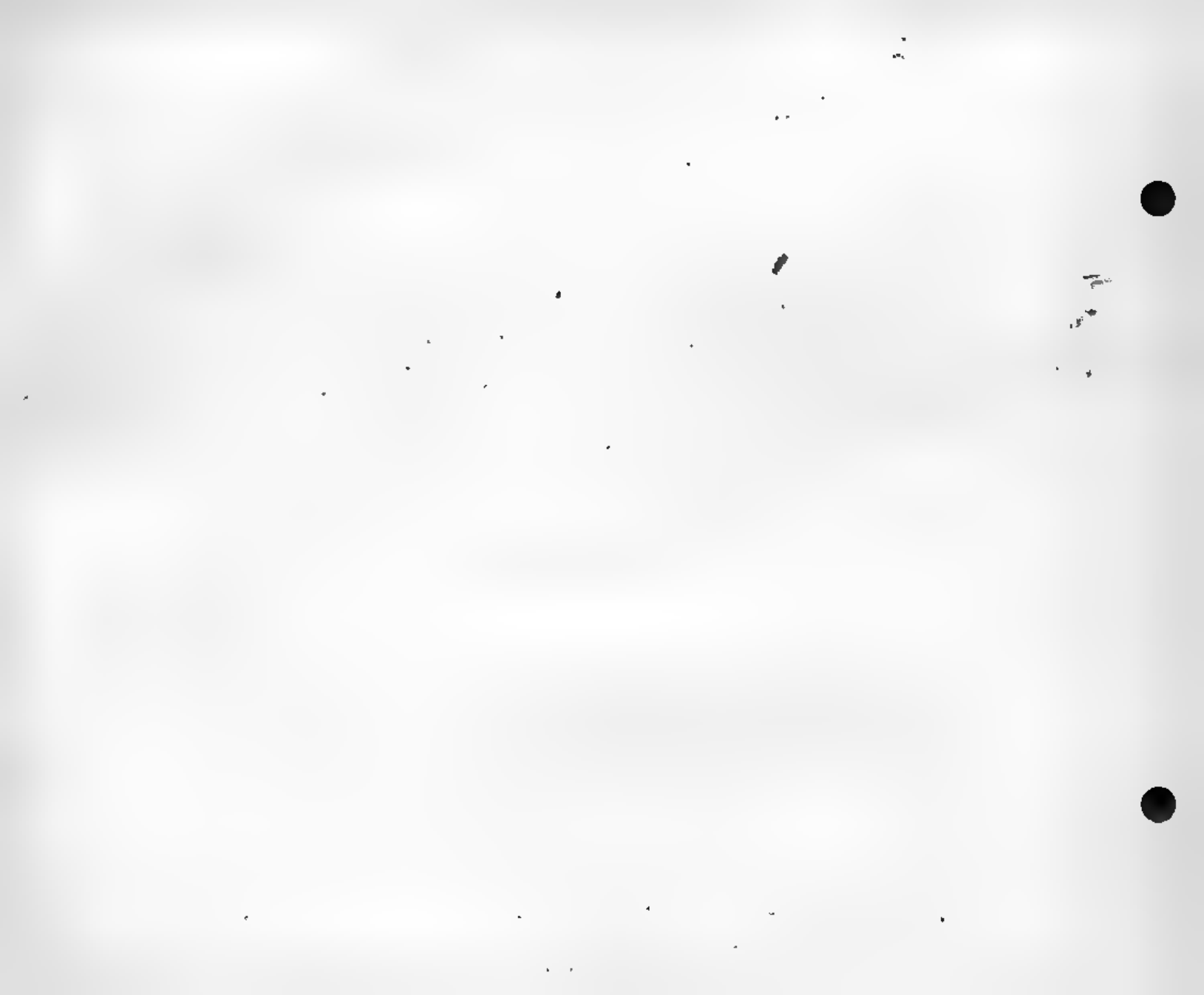
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 475 (7-68)  
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print) <u>Frederick W. Bowden</u>						2a. DATE OF DEATH Month <u>Aug.</u> Day <u>10</u> Year <u>68</u>			2b. HOUR <u>5:30</u> AM				
3 SEX <u>Male</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>May 17, 1916</u>			6 AGE (In years last birthday) <u>52</u> YRS.		7 UNDER YEAR MONTHS <u>52</u> DAYS <u>52</u>		8 UNDER 24 HRS HOURS <u>52</u> MIN <u>52</u>		
7a BIRTHPLACE (State or foreign country) <u>Mass.</u>			7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <u>Montgomery</u> Md.				
10 CITY OR TOWN OF DEATH <u>Silver Spring</u>			11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hosp.</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Neonographic</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Navy Dept.</u>				
13a USUAL RESIDENCE Where deceased lived if institut on Residence before admission) STATE <u>Maryland</u>			13b CITY OR TOWN <u>Oxon Hill</u>			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d STREET AND NUMBER <u>112-Panorama Drive</u>				
14 FATHER'S NAME First <u>Charles</u> Middle <u>Bowden</u> Last <u></u>						15 MOTHER'S MAIDEN NAME First <u>Ada</u> Middle <u>Starkie</u> Last <u></u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give date and where of service) <u>1942-43</u>			16b SOCIAL SECURITY NO <u>090140262</u>			17 INFORMANT (Daughter) <u>Nancy Smith, 112 Panorama Dr. Oxon Hill, Md.</u>			Address				
18 CAUSE OF DEATH Enter on any one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> (Conditions favor which gave rise to immediate cause (a) stating the underlying cause lost.)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a) <u></u>													
9a DATE OF OPERATION <u></u>			9b CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u></u>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. <u></u> Month <u></u> Day <u></u> Year <u>19</u> P.M. <u></u>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2. Item 18.) <u></u>							
22a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home - new, street, factory) (Office, building, etc.) <u></u>			21f LOCATION Street or R.F.D. No <u></u> City or Town <u></u> County <u></u> State <u></u>							
22a I certify that (I) (this hospital) attended the deceased from <u>7-27-1968</u> to <u>Aug 10 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 10 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d, d, did) view the body after death.													
22b SIGNATURE <u>Bernard A. Heekman, M.D. DEGREE</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c DATE SIGNED <u>Aug 11, 1968</u>				
22d PHYSICIAN'S NAME (Type) <u></u>						22e ADDRESS <u></u>							
23a BURIAL, CREMATION, or other disposition <u>Burial</u>			23b DATE <u>8-13-68</u>			23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			23d LOCATION (City or town County State) <u>Suitland, Maryland</u>				
24 FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> <u>4308 Suitland Rd. SE, Washington, D.C.</u>						25a REC'D BY REGISTRAR DATE <u>AUG 16 1968</u>			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATE



FOR STATE  
HEALTH DEPT.

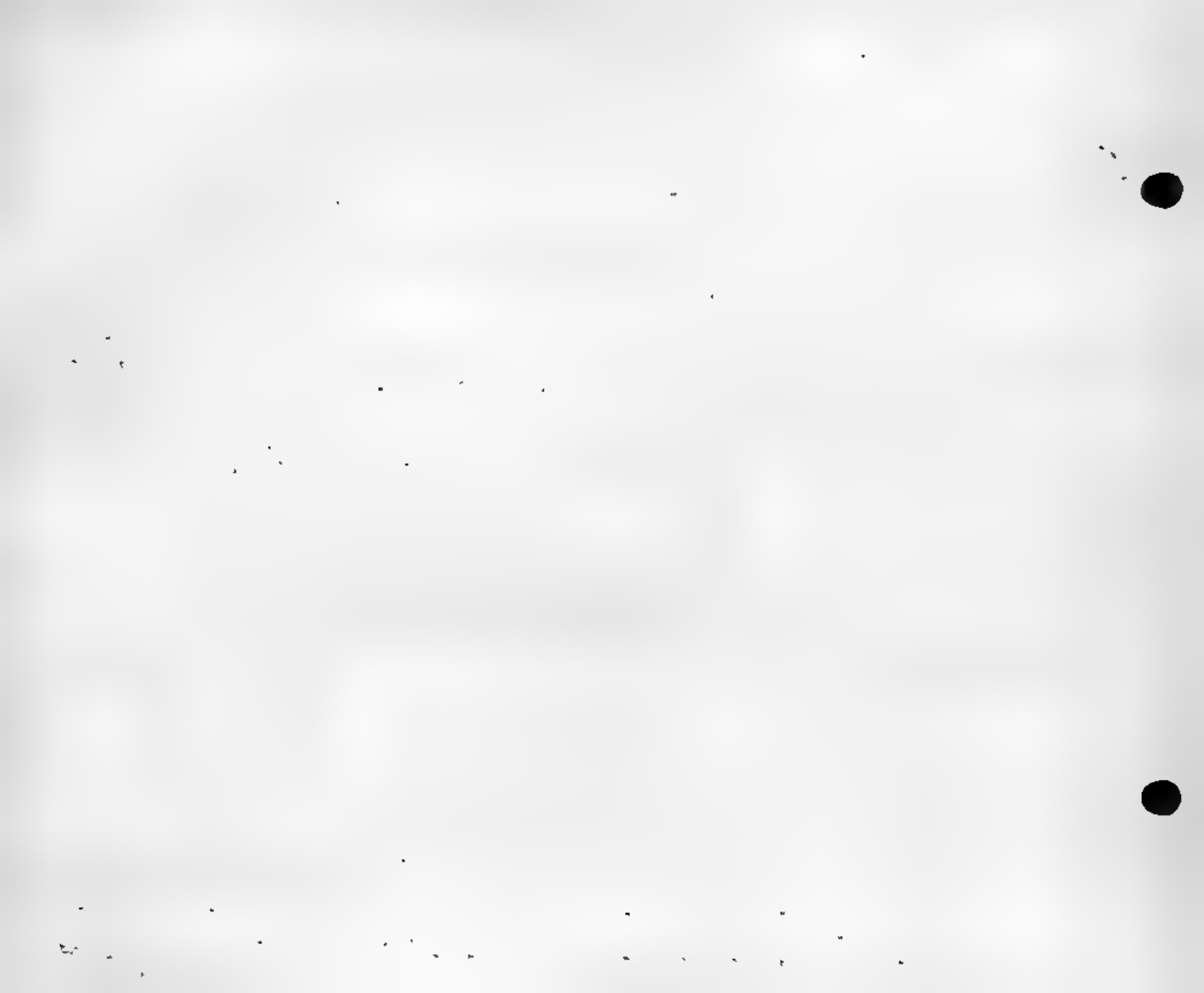
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office as original with the State Department of Health. 5 may be retained for your files.

GENERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

11662

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME Type of Print First Middle Last <b>LISTON BOWDEN</b>		2a. DATE KNOWN OF DEATH Month Day Year <b>8-7 68</b>		2b. HOUR Min <b>4:30</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUC.</b>	5. DATE OF BIRTH <b>SEPT. 10, '04</b>	6. AGE (in years) YRS. MONTHS DAYS <b>63</b>	7. IF UNDER 1 YEAR HOURS MIN <b>8-7</b>
7a. BIRTHPLACE State or foreign country <b>KANSAS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Montgomery</b>		10. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>None</b>		
11. CITY OR TOWN OF DEATH <b>Silver Spring</b>		12. NAME OF HOSPITAL OR NURSING HOME (If not in hospital give street address) <b>Randolph Hills Hospital</b>		13. KIND OF BUSINESS OR INDUSTRY <b>None</b>
14. FATHER'S NAME First Middle Last <b>William Knoden</b>	15. MOTHER'S NAME First Middle Last <b>Sylvia King</b>	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) <b>NO</b>		
17a. SOCIAL SECURITY NO. <b>562-03-3685</b>	17b. INFORMANT <b>Lorraine R. Bowden (Wife)</b>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE <b>129 Acute Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause: <b>(b) Atherosclerotic Heart Disease</b> <b>(c)</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>420</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF DEATH Month, Day Year HOUR A.M. P.M. <b>9</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2, item 18)		
22a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22b. PLACE OF INJURY (At home farm street factory office building, etc.)	22c. LOCATION (Street or RFD No. City or Town County State)		
22a. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Belden R. Keap</b>		CHIEF MED. CAL. EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>Aug. 7, 1968</b>
EXAMINER'S NAME Type <b>BELDEN R. KEAP, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22c. CITY or Town of County <b>Prince Geo. County, Md.</b>
23a. BURIAL REMAINS Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/>	23b. DATE <b>Aug. 8, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Ignace Cemetery</b>	23d. LOCATION (City or Town County State) <b>Prince Geo. County, Md.</b>	
24. FUNERAL DIRECTOR <b>Ernest E. Humphrey, Inc. 8434 Ga. Ave Sil Spg. Md.</b>		25a. RECD BY REGISTRAR <b>AUG 9 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation or removal and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
11662 8 vmp CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last Otha NONE Branch						2a. DATE OF DEATH 8 Month 25 Day 68 Year		2b. HOUR 5:08 PM			
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 9-24-97		6. AGE in years (last birthday) 70 YRS		7. INQUIRER MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS	
2a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? AMERICA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
0. CITY OR TOWN OF DEATH TAKOMA PARK, Md.		NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) WASHINGTON SAR & Hosp		12a. USUAL OCCUPATION Kind of work done during most of waking hours, even if retired RETIRED - CORRECTOR OF EXERCISE		12b. KIND OF BUSINESS OR INDUSTRY					
3a. USUAL RESIDENCE Where deceased lived, if institution Residence before admission) STATE DC		13b. COUNTY Washington		13c. CITY OR TOWN Washington		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 209 KANAWHA PL. N.E. - D.C.			
4. FATHER'S NAME First Middle Last C. F. B. Branch		5. MOTHER'S MAIDEN NAME First Middle Last Emily Austin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO		7. INFORMANT Eleanor B Silver		Address 222 Rittenhouse Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia of Distal Bleeding 2-3 wks DUE TO, OR AS A CONSEQUENCE OF Chronic kidney disease 2-4 yrs (b) Hemolyzed arterial vessels DUE TO OR AS A CONSEQUENCE OF Hypertensive Cardiovascular Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (c)											
19a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME - HOME, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 7-20-68 to 8-25-68 that (we) last saw the deceased alive on 8-25-68 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death											
22b. SIGNATURE Dr. R. Spencer M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 8-25-68					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8/28/68		23c. NAME OF CEMETERY OR REFORMATORY 1.		23d. LOCATION (City or Town) (County, State) Henderson, North Carolina					
24. FUNERAL DIRECTOR John T. Stewart		ADDRESS 4001 Benning Road, N.E.		RECD BY REGISTRAR DATE AUG 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA FORM 304 REV 1-68

11663

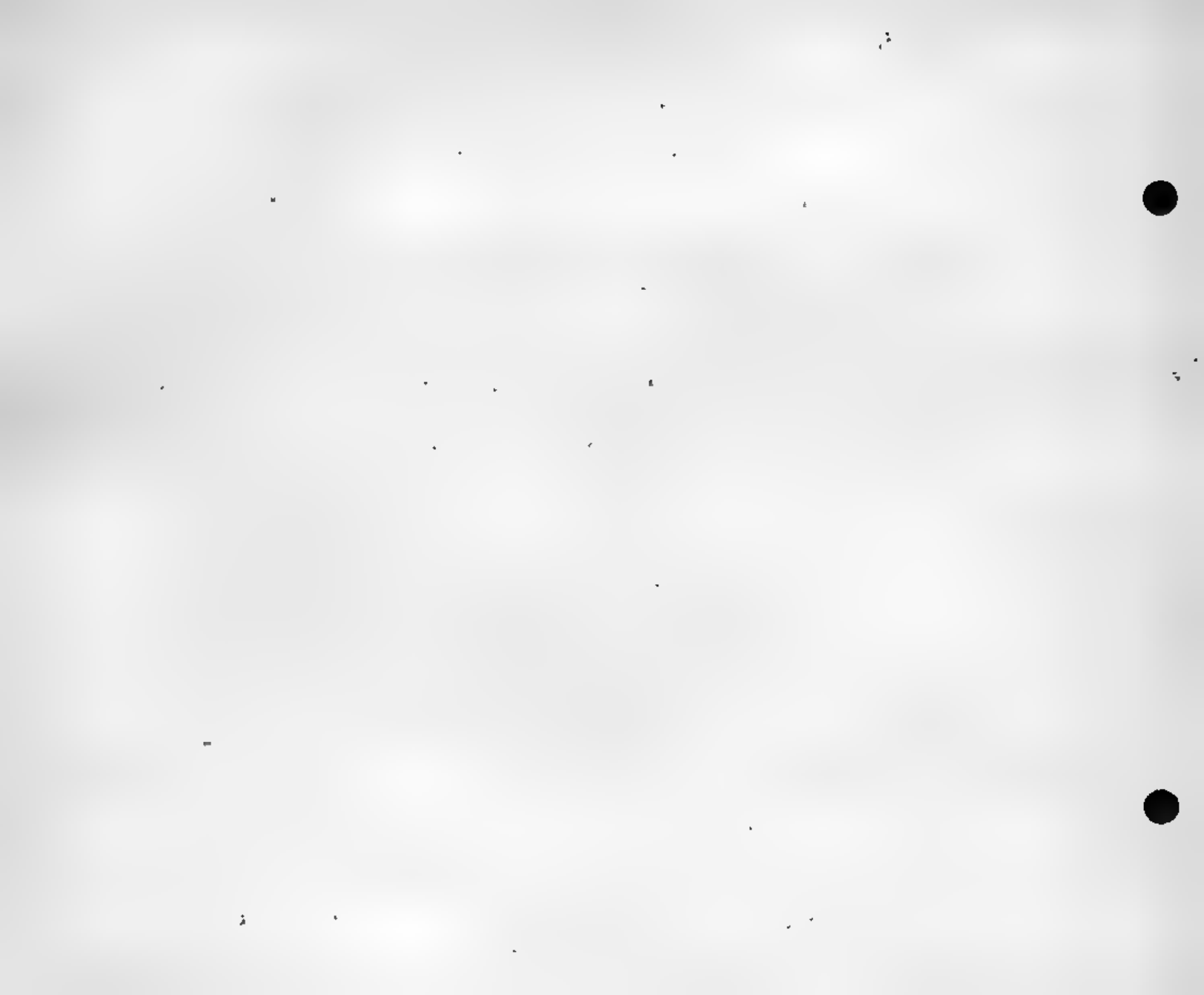
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1969

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
OLIVE		L.		BREADY	August 17 1968		8:20 AM	
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 24 HR	
Female	CAUC.		Sept. 29, 1877		YRS. MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Glenmont, Md.		U.S.A.				Montgomery		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, OR INSTITUTION, if not in hospital		12a USUAL OCCUPATION (Kind of work done during past year, or if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Kensington		Hall Sanitarium		during past year, or if retired		Own home		
3a USUAL RESIDENCE Where deceased lived, if institution Residence before admission, STATE		13b COUNTRY		13c CITY OR TOWN		13d INSIDE CITY LIMITS		13e STREET AND NUMBER
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9321 Warren Street
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		Address				
First Middle Last		First Middle Last						
William Cophas Hardy		Sarah A. Ball						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service)		16b SOCIAL SECURITY NO		7 INFORMANT				
No		215-54-7460		Mrs. Robert Hale 9321 Warren St., S. S., Md.				
18. CAUSE OF DEATH (Enter any one cause per line for a (b) and c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF LIVER</u> 197.8 DUE TO, OR AS A CONSEQUENCE OF (b) <u>197.8</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>197.8</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>SENILITY</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2. Item 18.)				
22d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		22e LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from <u>October 1 1963</u> , to <u>August 17 1968</u> , that (I) (we) lost the deceased alive on <u>August 17 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b SIGNATURE		DEGREE		ATTENDING PHYS		MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED
<u>Henry Lowden MD</u>								8/17/68
22d PHYSICIAN'S NAME (Type)		22e ADDRESS						
Henry Lowden		5206 NORWAY DR CHELSEA, MD						
23a BURIAL, CREMATION, REMOVAL, SPLICITY		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
		Aug. 20, 1968		St. John's Cemetery		Forest Glen, Maryland		
24 FUNERAL HOME		ADDRESS		25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Vernor E. Pumphrey, Inc.		8434 GARDENIA AVE. SILVER SPRING, MD.		DATE AUG 21 1968		<u>Charles Judge</u>		

MEDICAL CERTIFICATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The deceased remove carbon papers, Pages 5 and 2, should be filed with the State Dept. of Health prior to burial or cremation, or removal, and any event within 72 hours after death.

11664

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>VIRGINIA H BROMWELL</b>			2a. DATE OF DEATH Month <b>AUGUST</b> Day <b>24</b> Year <b>1968</b> 2b. HOUR <b>6:55</b> M		
3 SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>3-24-07</b>	
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>MONTGOMERY</b>			6. AGE (in years last birthday) <b>61</b> YRS.		
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>HOLY CROSS HOSP.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
13a. SOCIAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>	
14 FATHER'S NAME First Middle Last <b>James Harris</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Callie V Payne</b>		16a. SOCIAL SECURITY NO. <b>579-01-1691</b>	
17 INFORMANT <b>Berton A. Bromwell</b>		18. ADDRESS <b>same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hepatic Coma and Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Laennec's Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>2 yrs</b> (c) <b>2 yrs</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>myocardial ischemia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/3</b> <b>1968</b> to <b>8/24</b> <b>1968</b> , that (I) (we) last saw the deceased alive on <b>8/24</b> <b>1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <b>Israel Spector</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/24/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ISRAEL SPECTOR, M.D.</b>		22a. ADDRESS <b>911 Silver Spring Avenue Silver Spring, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>		24. FUNERAL DIRECTOR <b>The S.H. Hines Co. Washington, D. C.</b>			
25a. REC'D BY REGISTRAR <b>AUG 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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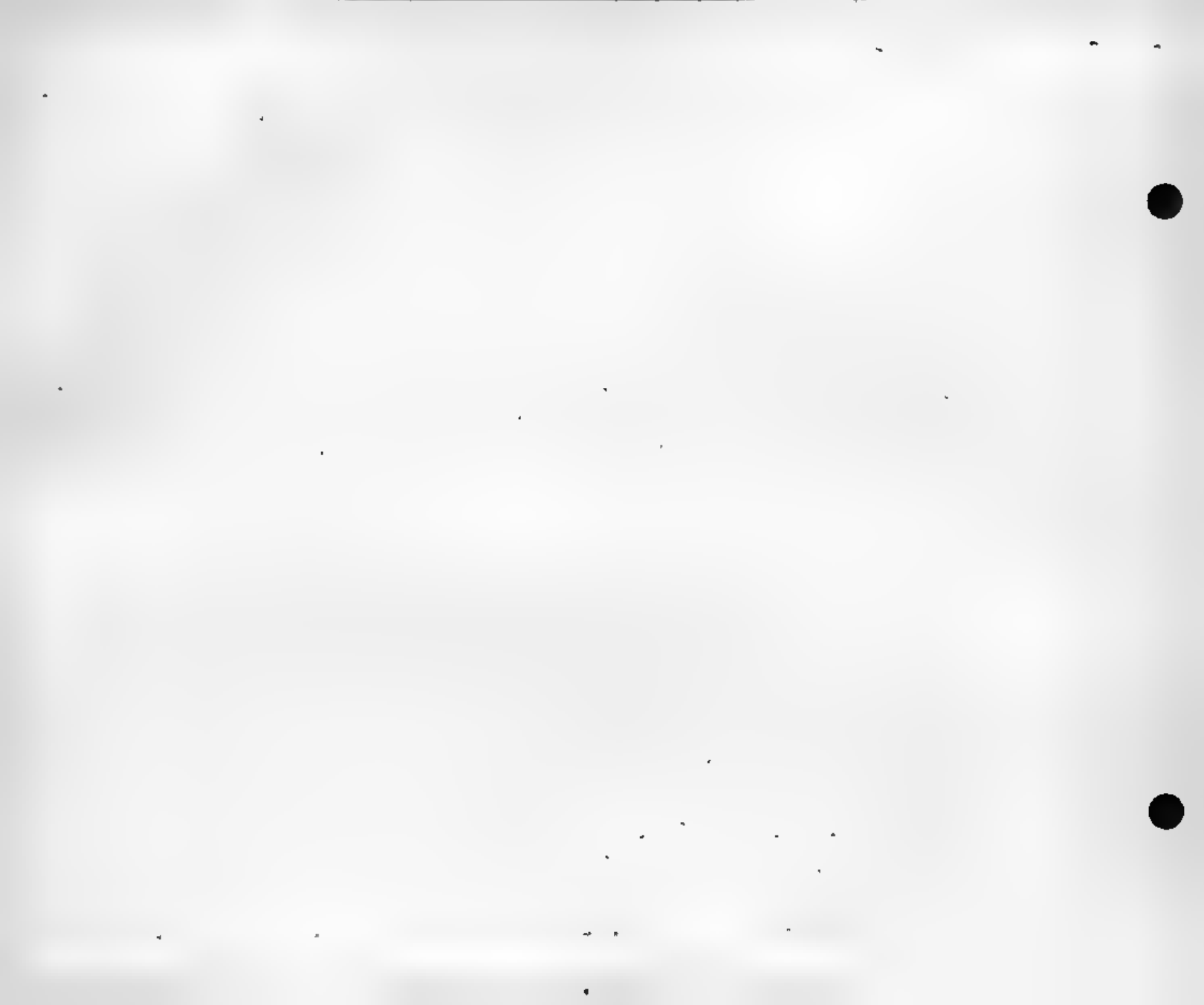
VR A15 (4)  
30M REV 1/64

11663

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 6 File 301  
**CERTIFICATE OF DEATH**

11663

1. DECEASED NAME (Type or print) First <u>ETIA</u> Middle <u>M.</u> Last <u>BROWN</u>			2a. DATE OF DEATH Month <u>AUGUST</u> Day <u>1</u> Year <u>1968</u>		2b. HOUR <u>1:00</u> PM
3. SEX <u>FEMALE</u>		4. RACE <u>W.</u>	5. DATE OF BIRTH <u>9-23-07</u>		6. AGE (in years last birthday) <u>60.61</u> YRS
7a. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>MONTGOMERY COUNTY.</u> Md.					
10. CITY OR TOWN OF DEATH <u>TACOMA PARK, MD</u>		11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <u>CAR HAVEN</u>		12a. USUAL OCCUPATION (kind of work done during most of working life even if retired) <u>DRUG STORE CLERK</u>	
13a. USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>	13c. CITY OR TOWN <u>SILVER SPRING</u>	3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <u>Marion</u> Middle <u>E</u> Last <u>Moxley</u>			15. MOTHER'S MAIDEN NAME First <u>Nannie</u> Middle <u>M</u> Last <u>McGaha</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war and dates of service)		16b. SOCIAL SECURITY NO <u>214-03-3351</u>		17. INFORMANT <u>Edward M Brown</u> Address <u>527 Dale DR. Silver Spring Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral adenocarcinoma of Gray</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) <u>5 months</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR <u>AM</u> Month <u>Day</u> Year <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2 Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that ( ) (this hospital) attended the deceased from <u>April</u> 19 <u>68</u> , to <u>Aug 1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>8/1/1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>BLAINE H ELLG</u>		22e. ADDRESS <u>9501927 1/2 1st St, Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-3-68</u>		23. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery Mt. Rainer Pr. Geo Md</u>	
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>		ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>AUG 5 1968</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word "pending" in parentheses. Item 8 Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>11666</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>											
1 DECEASED NAME Type or Print First Middle Last FRANCIS EARL BROWN						2a DATE KNOWN OF DEATH Month Day Year 8 - 8 1968			2b HOUR 5:07 PM		
1 SEX Male		4 RACE White		5 DATE OF BIRTH 9-11-08		6 AGE (In years last birthday) 59 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year 8 8 1968	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			2d HOUR 5:07 PM		
10 CITY OR TOWN OF DEATH Olney				11 NAME OF HOSPITAL OR INSTITUTION (Not at home give street address) Montgomery General Hospital				12a USUAL OCCUPATION Kind of work done during normal working life (even if retired) Guard		12b KIND OF BUSINESS OR INDUSTRY Correction	
3a USUAL RESIDENCE (Where deceased lived at institution Residence before admission) STATE Maryland				3b COUNTY Howard		3c CITY OR TOWN Laurel		3d WIDE CITY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3e STREET AND NUMBER Box 217, BFD #1	
4 FATHER'S NAME First Middle Last Scott f Brown				5 MOTHER'S MAIDEN NAME First Middle Last Pearl Brown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown, (If yes give year or date of service) No				6b SOCIAL SECURITY NO 215-05-3305		7 INFORMANT ADDRESS Olney, Md Admission Record, Montgomery General Hospital					
8 CAUSE OF DEATH (Enter only one cause per line for a, (b) and c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cholemia - severe DUE TO OR AS A CONSEQUENCE OF Conditions if any which gave rise to immediate cause (a) } stating the underlying cause } (b) obstruction of Common Bile Duct DUE TO OR AS A CONSEQUENCE OF Cholelithiasis in Cholecystitis, acute										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 ? 3 ? 4 1/2 ?	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				25 TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 9		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
22a IN INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				23 LOCATION Street or R.F.D. No City or town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> From side <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME Type BELDEN R. REAP M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b DATE SIGNED Aug. 8, 1968			
23a BURIAL, CREMATION, REMOVAL Specified				23b DATE 8/11/68		23c NAME OF CEMETERY OR CREMATORY Emmanuel Cem.		23d LOCATION City or town Seagoville Md.			
24 FUNERAL DIRECTOR Donald C. Shaw				25a RECD BY REGISTRAR AUG 14 1968		25b REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1, 2, 3, and 4, and show them to be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415  
304 REV. 1-68

11667

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1173

1. DECEASED NAME (Type or print) First ALMA Middle IRENE Last BRINE		2a. DATE OF DEATH Month 8 Day 27 Year 1968		2b. HOUR 6:36 PM
3. SEX FEMALE	4. RACE CAUS	5. DATE OF BIRTH 12/26/1898	6. AGE (In years last birthday) 69 YRS	IF UNDER 1 YEAR MONTHS 4 DAYS 2
7a. BIRTHPLACE (State or foreign country) BROCKTON MASS.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH BROCKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNIVERSITY NURSING HOME	12a. US. OCCUPATION (Kind of work done during most of working life, even if retired) BOOKKEEPER	12b. KIND OF BUSINESS OR INDUSTRY	
13a. US. RESIDENCE (Where deceased lived if institution Residence before admission) STATE MD	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BROCKTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 104 21 Edgewood Ave
14. FATHER'S NAME First Ira Middle E Last Parmenter	15. MOTHER'S MAIDEN NAME First Emma S. Middle L. Last Huntington	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No		
16b. SOCIAL SECURITY NO. 578-05-8666		17. INFORMANT Jean Miller Whelan, 5901 Quantrell Ave, Alex		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Largest heart failure DUE TO, OR AS A CONSEQUENCE OF (b) decreased circulation derived from DUE TO, OR AS A CONSEQUENCE OF (c) aneurysm in the aorta Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause 4 46 wk				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 300X generalized arteriosclerosis atherosclerosis				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item B.)		
21d. NATURE OF INJURY White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No	City or Town	County State
22a. I certify that this hospital attended the deceased from May 1968 to May 29 1968 that I (my) last saw the deceased alive on 6:30 PM 9 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we, (did) (did not) view the body after death				
22b. SIGNATURE Ernest E Harmon MD	22c. DATE SIGNED 27 May 68	22d. PHYSICIAN'S NAME (Type) Ernest E Harmon MD		
23a. BURIAL, CREMATION Cremation	23b. DATE Aug 31, 1968	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) Coomer Manor	(County) (State) MD
24. FUNERAL DIRECTOR L. H. H. H. H.	24a. ADDRESS 2500 W. W. H.	24b. CITY OR TOWN Baltimore	24c. STATE MD	24d. ZIP CODE 21201
25a. FILED BY REGISTRAR DATE SEP 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY CHIEF MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Pages 5 and 6, along with form PM-1, Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

11668

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

DECEASED NAME (Type in Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR		
EMILY Louise		BURGESS						8-12		68		6		25		A.M.		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE	7 UNDER 24 HRS		8 MONTHS		9 DAYS		10 HOURS		11 MIN		2c DATE PRONOUNCED DEAD		2d HOUR	
Female	CAUC	8-8-'83		85	YRS										8-12		68	
7a BIRTHPLACE, State or foreign		7b CITIZENSHIP OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH										
WASH., D.C.		U.S.A.		WIDOWED		DIVORCED		Montgomery										
10 CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (if not in hospital)		12a SOCIAL OCCUPATION (kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY												
OLNEY		BROOKE GROVE FOUND		BANK CLERK		BANK												
13a U.S. RESIDENCE (Where deceased lived 1 year or more before death)		13b COUNTY		13c CITY OR TOWN		13d STREET AND NUMBER		13e STREET AND NUMBER		13f STREET AND NUMBER		13g STREET AND NUMBER		13h STREET AND NUMBER		13i STREET AND NUMBER		
Md		Montgomery		S.S.		353 S. Hampton Dr.		S.S.		Md.								
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last				
JOHN W.		BURGESS						ELLA								RYAN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS												
No		Yes		Mary B. Colie		353 S. Hampton Dr. S.S., Md.												
18 CAUSE OF DEATH (Enter only one cause per line, but if more than one, list them in order of importance)		PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		(b)		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
486x		Bilateral Pneumonitis																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		(c)														
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		(b)		(c)														
Generalized Arteriosclerosis																		
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20 AUTOPSY?		YES		NO										
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)														
22a INJURY OCCURRED WHILE AT WORK		22b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		22c LOCATION (Street or R.F.D. No)		City or Town		County		State								
22a I certify that I took charge of the remains described above, held on death rested from		Not to causes		Accident		Suicide		Homicide		Undetermined manner								
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED										
Belden R. Reap								Aug 12, 1968										
EXAMINER'S NAME (Type)		23a BIRTHAL CREMATORY		23b DATE		23c NAME OF CREMATORY		23d LOCATION (City or Town)		County		State						
Belden R. Reap		Burial		Aug 14, 1968		Mt. Olivet		Washington, D.C.										
24 FUNERAL DIRECTOR		ADDRESS		25a REGISTRATION		25b REGISTRAR'S SIGNATURE												
Warner E. Pumphrey, Inc.		8434 Ga. Ave. S.S., Md.		Aug 16 1968		Charles Judge												



11669

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1968

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print) <i>Mildred F Burke</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>8</i> Day <i>2</i> Year <i>1968</i>			2b. HOUR <i>7:30</i> MIN <i>AM</i>		
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>11/27/08</i>	6. AGE (in years) <i>59</i> YRS	7. UNDER 24 HRS MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN	2c. DATE PRONOUNCED DEAD Month <i>8</i> Day <i>2</i> Year <i>1968</i>			2d. HOUR <i>7A</i> MIN <i>AM</i>
7a. BIRTHPLACE (State or foreign country) <i>New York U.S.A.</i>			7b. CIT. (IN OR WHAT COUNTRY?) <i>U.S.A.</i>			8. COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			2e. U.S.A. OCCUPATION, kind of work done during past 10 working days, if over 10 days, give street address <i>Housewife</i>		
3a. U.S.A. RESIDENCE (Where deceased lived at institution, residence before admission) STATE <i>Florida</i>			13b. COUNTY <i>Delaware</i>			13c. STREET AND NUMBER <i>86 MacFarlane Drive</i>		
14. FATHER'S NAME <i>George Fischer</i>			MOTHER'S MAIDEN NAME <i>Bloom</i>					
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or none) <i>no</i>			16b. SOCIAL SECURITY NO. <i>in Baltimore</i>			17. INFORMANT <i>Husband - Kenneth - Same</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Skull fracture and cerebral contusion</i>								<i>7 days</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Auto accident</i>								
DUE TO, OR AS A CONSEQUENCE OF (c) <i>lost</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION <i>8/1</i>								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month <i>July</i> Day <i>26</i> Year <i>1968</i>			21c. HOW INJURY OCCURRED: Enter nature of injury in Part 1 or Part 2, item 8. <i>Passenger in car involved in collision with another car</i>		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, dining, etc.) <i>Highway</i>			21f. LOCATION (Street or RFD No, City or Town, County, State) <i>Falls Road - Potomac - Montgomery Md</i>		
22a. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>			EXAMINER'S NAME (Type) <i>John G Ball</i>			22b. DATE SIGNED <i>August 2, 1968</i>		
23a. BURNAL CREMATION R. MOVAL SPECIFY <i>Burnal</i>			23b. DATE <i>8-6-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Soldiers Field</i>		
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>			ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>		
						25b. REGISTRAR'S SIGNATURE		





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Only the necessary pages execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit five pages later with this certificate. Health prior to burial of cremation or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11670 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1a DECEASED NAME [Type or Print] First Middle Last <b>DR KENNETH DUNCAN CAMPBELL MD</b>						2a DATE KNOWN OF DEATH Month Day Year <b>8 25 68</b>		2b HOUR <b>7:10A</b>	
3 SEX <b>Male</b>	4 RACE <b>white</b>	5 DATE OF BIRTH <b>9-9-12</b>	6 AGE in year (last birthday) <b>55 YRS</b>	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month Day Year <b>8 25 1968</b>		2d HOUR <b>AM</b>	
7b BIRTHPLACE State or foreign country <b>Nova Scotia</b>		7c CITIZEN OF WHAT COUNTRY? <b>USA</b>		9 COUNTY OF DEATH <b>Montgomery</b>		10 CITY OR TOWN OF DEATH <b>Takoma Park</b>			
NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Washington San &amp; Hosp</b>				2a USUAL OCCUPATION kind of work done during most of working life even if retired <b>Physician</b>		2b KIND OF BUSINESS OR INDUSTRY			
3a USUAL RESIDENCE where deceased resided before death City or town State <b>Maryland Prince Geo. College</b>		13a INSIDE TELEPHONE YES <input type="checkbox"/> NO <input type="checkbox"/>		13b STREET AND NUMBER <b>9710 Rhode Island Ave</b>					
4 FATHER'S NAME First Middle Last <b>Scott Campbell</b>			5 MOTHER'S MAIDEN NAME First Middle Last <b>Florence Parker</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			
6b SOCIAL SECURITY NO <b>UNKNOWN</b>			17 INFORMANT <b>Hospital record</b>			ADDRESS			
18b CAUSE OF DEATH Enter in any one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fulmonary embolus, acute</b> <b>DDH</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) <b>Thrombus of veins of left leg</b> DUE TO OR AS A CONSEQUENCE OF <b>Dislocation of left hip</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>90</b>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month Day Year ? AM <b>Aug 23 1968</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 6) <b>Dislocated hip when getting out of chair</b>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (at home farm street factory office building etc) <b>Home</b>		21f LOCATION Street or R.F.D. No City or Town County State <b>9710 Rhode Island Ave College Park PG Md.</b>					
22a I certify that I took charge of the remains described above held in Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>BELDEN R. KEAP</b>		EXAMINER'S NAME Type <b>BELDEN R. KEAP MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS City or town County State <b>College Park PG Md</b>		22b DATE SIGNED <b>8/25/1968</b>			
23a BURIAL CREMATION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/>		23b DATE <b>Aug 29 1968</b>		23c NAME OF CEMETERY OR FURNERARY <b>FORT LINCOLN CEM</b>		23d LOCATION City or town County State <b>COLMAR MANOR MARYLAND</b>			
24 FUNERAL DIRECTOR <b>W.W. Chambers</b>		ADDRESS <b>1400 Capital Bldg</b>		25a RECD BY REG STRAR <b>SEP 3 1968</b>		25b REG. STRAR'S SIGNATURE <b>Charles Judge</b>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

78

FOR STATE HEALTH DEPT.

11671

DECEASED NAME Type or Print		First	Middle	Last	2a DATE KNOWN OF DEATH	Month	Day	Year	2b HOUR
Lacy		Arless	Canterbury		8-3	68	6	30	A
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	7 IF MARRIED	8 YEAR	9 MONTHS	10 DAYS	11 HOURS	12 MIN
Male	Cauc.	Dec. 14, 1906	61	NEVER MARRIED					
7a BIRTHPLACE	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	9 COUNTY OF DEATH						
West Virginia	U.S.A.	NEVER MARRIED	Montgomery						
10 CITY OR TOWN OF DEATH	NAME OF HOSPITAL OR INSTITUTION (if not in hospital)		2c USUAL OCCUPATION (if not at work done during last 12 months)	12b KIND OF BUSINESS OR INDUSTRY					
Takoma Park	Washington San & Hospital		Ret. Contractor	Building					
3a USUAL RESIDENCE	3b CITY OR TOWN	3c INSIDE CITY LIMITS?	3d STREET AND NUMBER						
an. land	Silver Spring	YES	112 Whitmoor Terrace						
4 FATHER'S NAME	5 MOTHER'S MAIDEN NAME								
James B.	Annie Elizabeth Comer								
6a WAS DECEASED EVER IN U.S. ARMED FORCES?	6b SOC. A. SECURITY NO.	17 INFORMANT	ADDRESS						
no	214-03-9567	Mrs. Dannah B. Canterbury	Silver Spring, Md.						
18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c).)									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Exsanguination due to blood loss from ruptured abdominal aortic aneurysm.</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR UNDERLYING CAUSE (b) <u>Arteriosclerotic Heart Disease.</u>									
9a DATE OF OPERATION	9b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?							
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21 a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21 b TIME OF INJURY Month Day Year	21 c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18.)							
22 a INJURY OCCURRED WHILE <input type="checkbox"/> A WORK <input type="checkbox"/> NOT WHILE A WORK <input type="checkbox"/>	22 b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	22 c LOCATION (Street or R.F.D. No. City or Town County State)							
22a I certify that I took charge of the remains described above held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b DATE SIGNED									
22c NAME OF CHIEF MEDICAL EXAMINER									
22d NAME OF DEPUTY MEDICAL EXAMINER									
22e NAME OF REGISTRAR									
22f NAME OF REGISTRAR'S CLERK									
23a BIRTH OF CREMATION REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town County State)						
	Aug. 5, 1968	St. Lincoln Cemetery	Prince George Co., Maryland						
24 FUNERAL DIRECTOR	25a REC'D BY REGISTRAR								
Warner E. Pumphrey, Inc.	25b REGISTRAR'S SIGNATURE								
	DATE AUG 7 1968								

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with term PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. It is pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



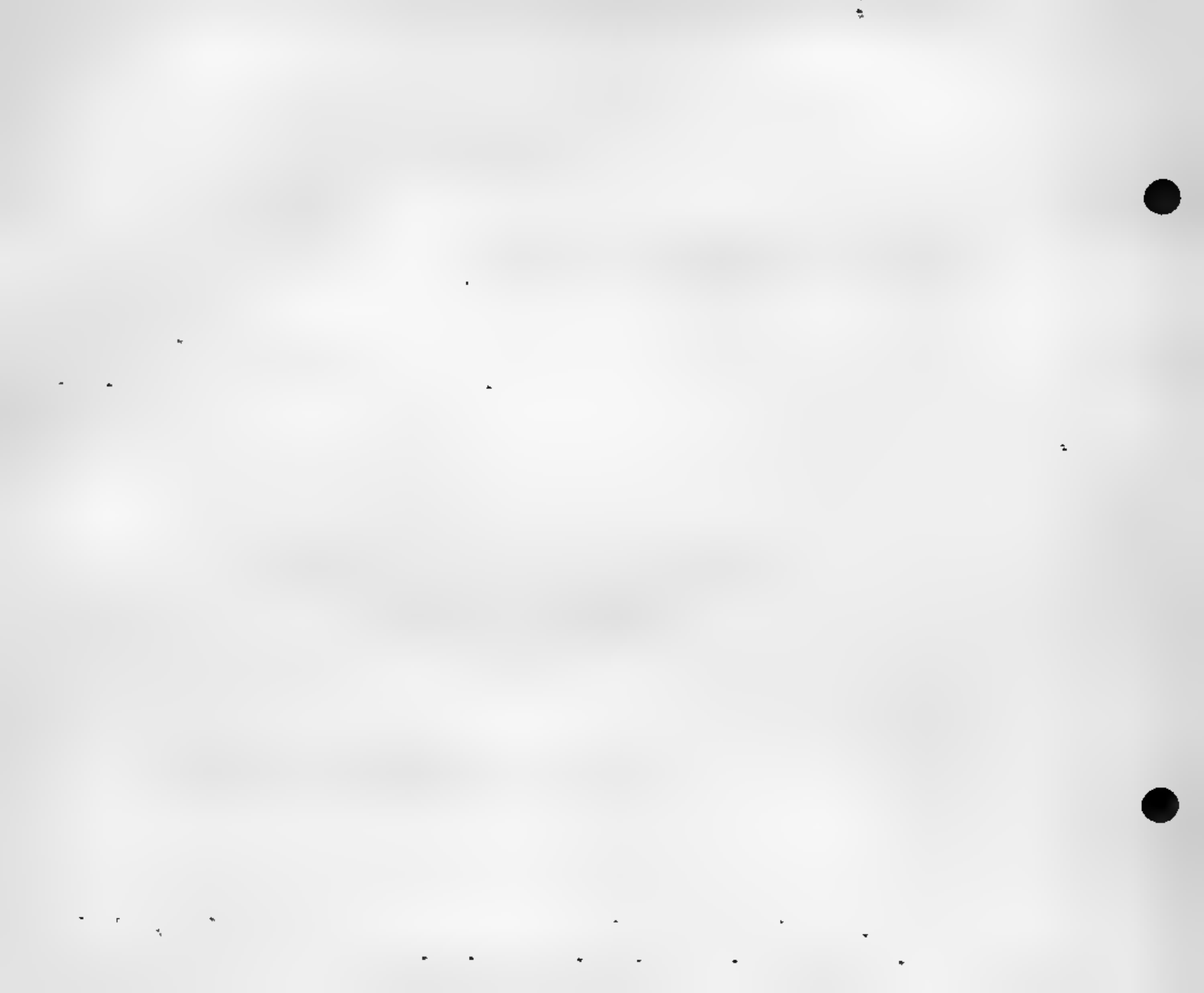
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department at Health prior to burial, cremation, or removal and in any event within 72 hours after death.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

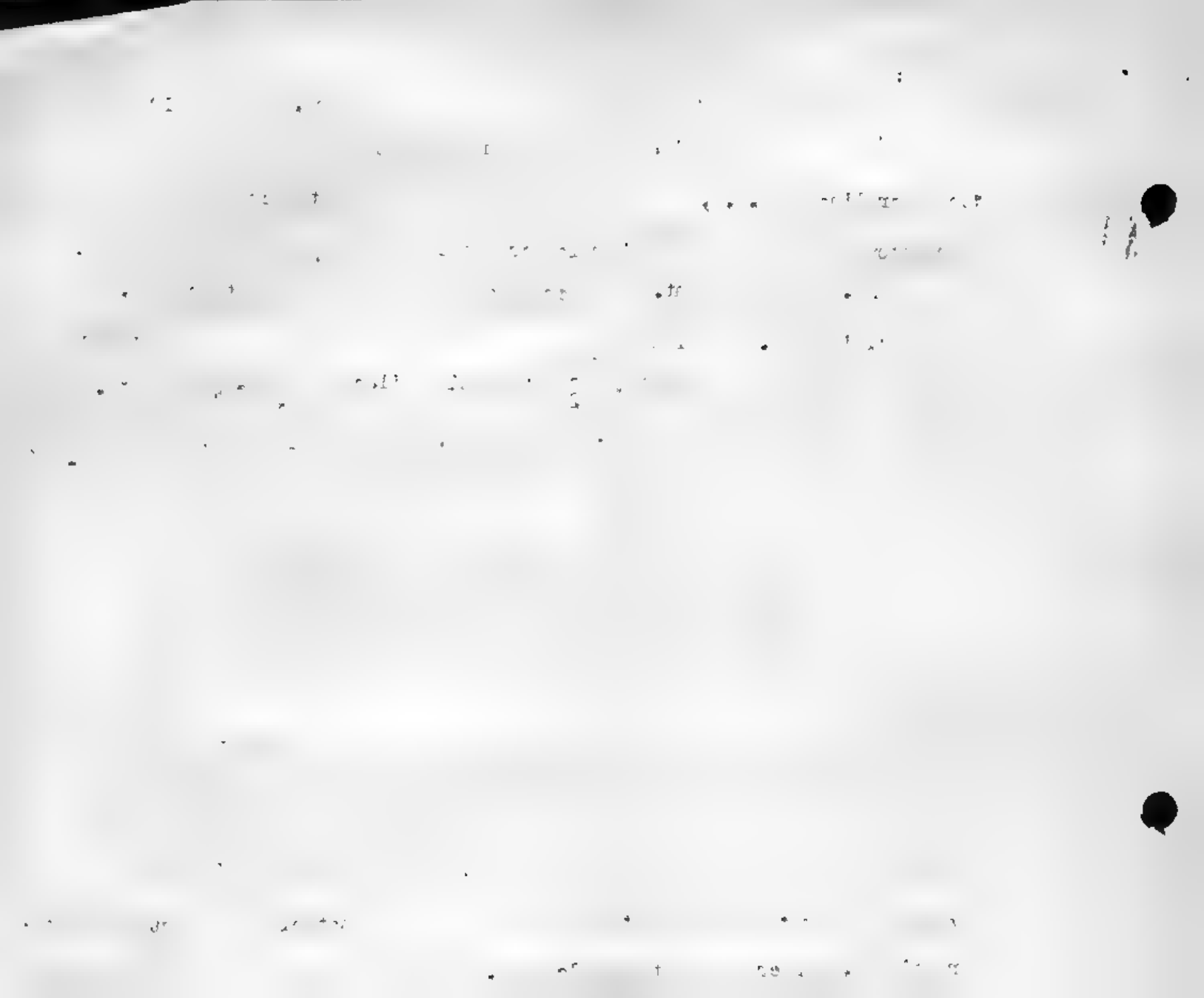
1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH	Month	Day	Year	2b HOUR
Annie Virginia Carman					ESTIMATED	8	7	1968	M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE in years	7 IF UNDER 1 YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR	
F	W	10-18-99	68	MONTHS	DAYS	MONTHS	MIN	8	11:50 A
7a BIRTHPLACE (State or foreign country)		7b STATE OF BIRTH		8 MARRIED		9 COUNTY OF DEATH			
Va.		USA		NEVER MARRIED		Montgomery			
10 CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (if not in hospital)		2a USUAL OCCUPATION		2b KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Hatch San & Hospital		Housewife		own home			
13a USUAL RESIDENCE (Where deceased lived, institution or residence before admission)		3b CITY		3c CITY OR TOWN		3d STREET AND NUMBER			
Maryland		Montgomery		Silver Spring		8510 Greenwood Ave			
14 FATHER'S NAME		15 MOTHER'S M.A.DEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO		17 INFORMANT	
Charles E. White		Minnie V. Guthridge		NO		207-03-7741		Mrs. Mary Tapscott Sister, Takoma Pk. Md.	
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c)									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE a. Acute myocardial infarction associated									
4109 DUE TO, OR AS A CONSEQUENCE OF with rupture of left ventricle,									
DUE TO OR AS A CONSEQUENCE OF hemopericardium and cardiac tamponade									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a DATE OF OPERATION									
19b CONDITION FOR WHICH OPERATION WAS PERFORMED									
20 AUTOPSY? YES X NO									
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH									
21b TIME OF INJURY Month Day Year									
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 8)									
22a INJURY OCCURRED									
22b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)									
22c LOCATION (Street or R.F.D. No., City or Town, County, State)									
22a I certify that, took charge of the remains described above, held an autopsy and in my opinion death resulted from Natural causes X Accident Suicide Homicide Undetermined manner									
22b CHIEF MEDICAL EXAMINER									
22c ASSISTANT MEDICAL EXAMINER									
22d DEPUTY MEDICAL EXAMINER									
22e DATE SIGNED Aug. 7, 1968									
23a BURIAL, CREMATION, REMOVAL (Specify)									
23b DATE									
23c NAME OF CEMETERY OR CREMATORY									
23d LOCATION (City or Town, County, State)									
24 FUNERAL DIRECTOR									
25a BY REGISTRAR									
25b BY REGISTRAR									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 13 Film G. 11672										
CERTIFICATE OF DEATH										
11680										
1 DECEASED NAME (Type or print)			First MABEL J Middle CARRAWAY Last			2a. DATE OF DEATH		2b. HOUR		
						Aug. Month 25 Day 1968 Year		6 A M		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		Aug 10 1878		90 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
North Carolina		U.S.A.				Montgomery Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most or working, to even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Germantown			Marylander Home			H.Wife		Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. STREET AND NUMBER		13d. CITY OR TOWN		
Md.			Mont.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Germantown Md.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last William A. Glenn			First Middle Last Ada Walker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give unit or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address		
No			579 38 1443			Virginia Wilson		Gaithersburg Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u>									<u>20 years?</u>	
DUE TO OR AS A CONSEQUENCE OF <u>9 years</u>										
(b) DUE TO OR AS A CONSEQUENCE OF <u>—</u>										
(c) DUE TO OR AS A CONSEQUENCE OF <u>—</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
42										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
—			—			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
			HOUR A.M. Month Day Year P.M. 19							
22a. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (this hospital) attended the deceased from Jan. 19 65 to Aug. 25, 1968, that (we) last saw the deceased alive on August 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d) (do) (not) view the body after death										
22b. SIGNATURE <u>M. M. KENDRICK BOYER, M.D.</u>						22c. DATE SIGNED <u>8/25/68</u>				
22d. PHYSICIAN'S NAME (Type) <u>M. M. KENDRICK BOYER, M.D.</u>						22e. ADDRESS <u>9701 Church St., Jamason, Va.</u>				
23a. BURIAL, CREMATION, REMOVAL, SPECIFY			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Removal			Aug. 25 1968			Oakmont		Gastonia North Carolina		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis H. Barber					Laytonsville Md.		DATE AUG 27 1968		<u>Charles Judge</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
MARY		ELIZABETH		CARROLL				Month 18 Day 31 Year 1968		2b HOUR 8:30	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOUR MIN.		2c DATE PRONOUNCED DEAD		2d HOUR
Female	White	10/29/46		21 YRS					Month 8 Day 31 Year 1968		2d HOUR 8:52
7a. BIRTHPLACE (State or foreign country)		7b. (If citizen of what country?)		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Massachusetts		USA				Montgomery					
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a U.S. A. OCCUPATION Kind of work done (If most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Silver Spring				Holy Cross Hosp.				Secretary, U.S. Navy		Sgt. Andrew La	
3a U.S.A. RESIDENCE (Where deceased had admission)		3b COUNTY		3c CITY OR TOWN		3d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e STREET AND NUMBER			
Washington		Washington		Sil. Spr.				605 St. Andrews Lane			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Louis J. Doyle				Sara B. Chase							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
NO				213-45-9857		Joseph A. Carroll 605 St. Andrews Lane Sil. Spr., Md.					
18 CAUSE OF DEATH (Enter only one cause per part (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia & broncho pneumonia										1 week	
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Multiple burns 3rd degree on 5% of body										6 days	
(c) Trauma from auto accident										16 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
Pregnancy											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, then 18)							
		9 HOUR A.M. 7-15 1968		Auto she was driving struck by truck, caught fire.							
22a IN JURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY At home, farm, street, factory, office building, etc.		21f LOCATION Street or RFD No		City or Town		County		State	
		Highway		Route 29		Montgomery		Md.			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		22b DATE SIGNED									
Belden R. Keap		Aug. 31, 1968									
EXAMINER'S NAME Type		22c DEPUTY MEDICAL EXAMINER ADDRESS (City or town, county)									
Belden R. Keap M.D.		Silver Spring, Md.									
23a BURIAL, CREMATION, REMOVAL, SPECIFY		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION City or town		County		State	
Burial		8-4-1968		Gate of Heaven Cemetery		Silver Spring, Md.					
24a PREPARED BY REG. STRAR		24b REG. STRAR SIGNATURE									
SEP 5 1968		Charles Judge									



FOR STATE  
HEALTH DEPT.

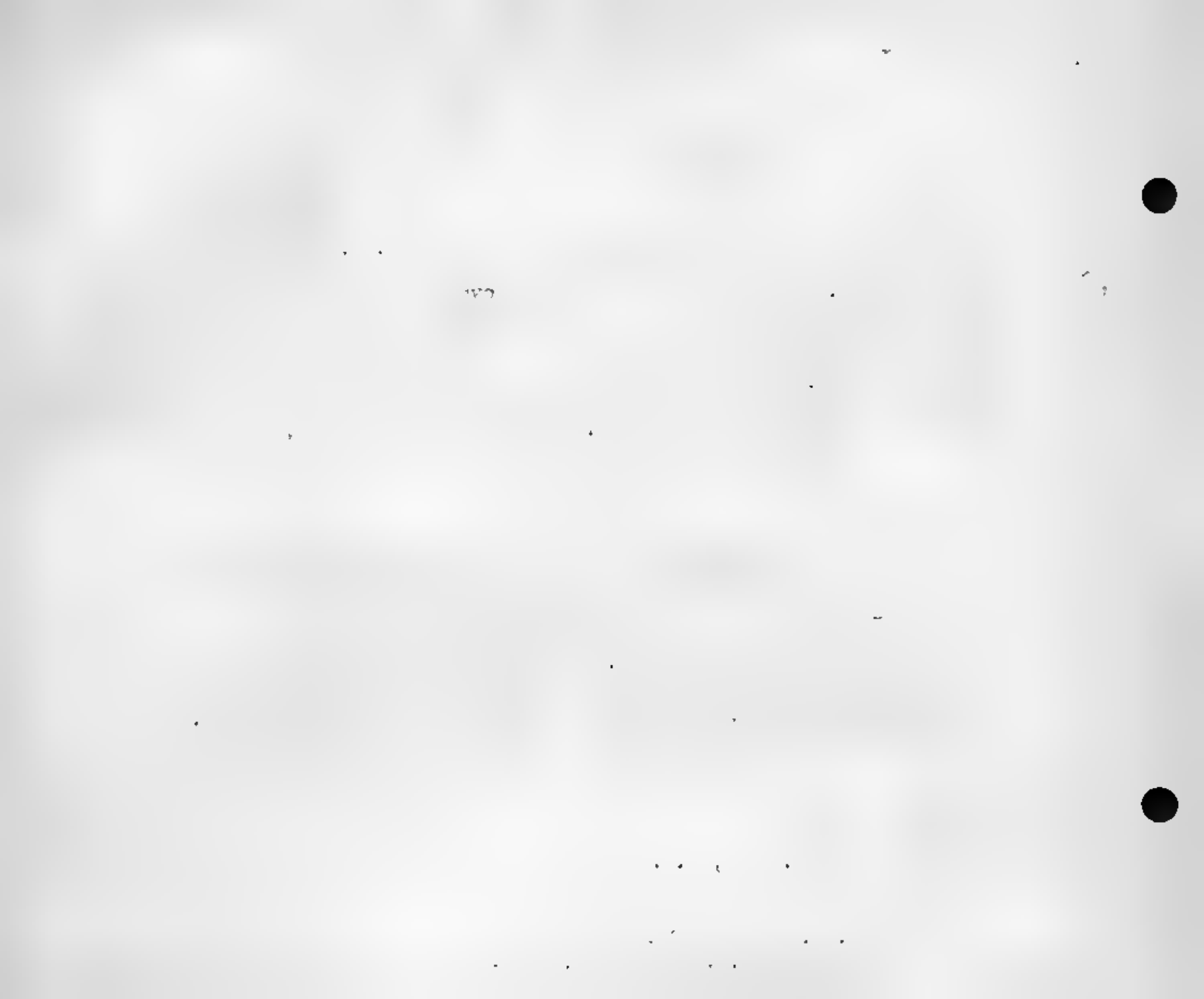
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11675

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Robert Alan CASTOR						Month Day Year			1968 5 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years)	if UNDER 1 YEAR		if UNDER 24 HRS		21 DATE PRONOUNCED DEAD			2d HOUR
Male	Cauc	18 JAN 1947	21 YRS	MONTHS	DAYS	HOUR	MIN	Month Day Year			500 PM
7b BIRTHPLACE (State or foreign country)			7c CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Pennsylvania			USA						Montgomery Md		
10 CITY OR TOWN OF DEATH			NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			2a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			2b KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital			U. S. Navy					
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			3b COUNTY			3c CITY OR TOWN			3d STREET AND NUMBER		
Penn.						Pottstown YES <input type="checkbox"/> NO <input type="checkbox"/>			1017 Sycamore Drive		
14 FATHER, NAME			5 MOTHER'S M A DEN NAME								
Ellis Robert Castor			Josephine Specht								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			6b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
yes			1965-68			210368195			Navy records		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN INJURY AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Head injuries, severe due to trauma from auto accident										29 1/2 hr	
DUE TO OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost											
(b) DUE TO OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
9a DATE OF OPERATION			9b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY?					
8-18-68			Subdural hematomas			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
2a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			2b TIME OF INJURY Month Day Year			2c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item B)					
			1130 P.M.			Passenger in car that run off highway					
2d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21a PLACE OF INJURY (At home, farm, street, factory, office building, etc)			2c LOCATION Street or RFD No			City or Town		
			highway			Route 5, near Leonardtown, Md.			County State		
22a I certify that I took charge of the remains described above held on death resulted from Autopsy <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspect an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED					
John G. Ball			Assistant Medical Examiner <input type="checkbox"/>			19 August 1968					
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)					
John G. BALL, M.D.											
23a BURIAL CREMATION			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)		
Burial			8-22-68			Highland Memorial Cemetery Pottstown, Pennsylvania			County State		
24 FUNERAL DIRECTOR			25a RECD BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
W. W. Chambers Co.			1400 Chapin Street, N.W. Washington, D. C.			AUG 23 1968			J Charles Judge		



FOR STATE  
HEALTH DEPT

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 6 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1a DECEASED NAME First Middle Last <b>ALPHONZO CHANDLER</b>					2a DATE KNOWN OF DEATH Month Day Year <b>8-8 1968</b>		2b HOUR <b>3 p.m.</b>		
3 SEX <b>Male</b>	4 RACE <b>Negro</b>	5 DATE OF BIRTH <b>10/14/33</b>	6a AGE in years (last birthday) <b>34 35</b> YRS	6b IF UNDER 24 HRS MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year <b>8 8 1968</b>		2d HOUR <b>3 p.m.</b>		
7a BIRTHPLACE (State or foreign country) <b>DANVILLE, VA.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Mon. Jernery</b>			
10 CITY OR TOWN OF DEATH <b>Takoma Park, Md.</b>		NAME OF HOSPITAL OR INSTITUTION (Not in hospital give street address) <b>Wash. San. &amp; Hosp.</b>		12c SOCIAL OCCUPATION Kind of work done during most of working life even if retired. <b>LABORER</b>		2b KIND OF BUSINESS OR INDUSTRY			
13a SOCIAL SECURITY NUMBER (Where deceased lived at institution or residence before admission) STATE <b>D.C.</b>		13b COUNTY <b>Washington</b>		3c CITY OR TOWN <b>Washington</b>		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e STREET AND NUMBER <b>1228 8th Street N.W.</b>	
4 FATHER'S NAME First Middle Last <b>EDDIE CHANDLER</b>					5 MOTHER'S MAIDEN NAME First Middle Last <b>FERRY MAE FRIDAY</b>				
6a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>		6b SOCIAL SECURITY NO		7 INFORMANT ADDRESS <b>JAMES CHANDLER DANVILLE, VIRGINIA</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio respiratory failure, acute</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>Undetermined</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>Undetermined</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
2a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		2b. TIME OF INJURY Month Day Year HOUR A.M. P.M. <b>19</b>		2c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8)					
2d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR AT HOME <input type="checkbox"/>		2e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		2f. LOCATION Street or R.F.D. No City or Town County State					
22a I certify that I took charge of the remains described above held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE <b>Belden R. Reap, M.D.</b>		EXAMINER'S NAME (Type) <b>Belden R. Reap, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>Aug. 8, 1968</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>8. .68</b>		23c NAME OF CEMETERY OR CREMATORY <b>1820 9TH ST. N.W. WASHINGTON, D.C.</b>		23d LOCATION City or Town County State <b>DANVILLE VIRGINIA</b>		25a REC'D BY REG. STRAR <b>DATE AUG 13 1968</b>	
24 FUNERAL DIRECTOR <b>Charles Judge</b>		25b REG. STRAR'S SIGNATURE <b>Charles Judge</b>							



11677

84

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH			Month Day Year			2b HOUR			
LEONA			REGINA			CHRISTIAN			AUG. 18, 1968			1258 M			
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (years as birthday)			7c DATE PRONOUNCED DEAD			
FEMALE			WHITE			12/15/1971			53 YRS			AUG 18 Year 1968 1258 M			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH						
MISSOURI			U.S.A.						MONTGOMERY						
10 CITY OR TOWN OF DEATH			NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			2a USCA OCCUPATION Kind of work done during last 12 months (even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
ROCKVILLE			259 CONGRESSIONAL LANE			HOUSEWIFE									
3a USAL RESIDENCE Where deceased lived, institution Residence before admission to State			13b COUNTRY			3c CITY OR TOWN			4c INSURE? YES <input type="checkbox"/> NO <input type="checkbox"/>			13a STREET AND NUMBER			
MARYLAND			MONTGOMERY			ROCKVILLE						259 CONGRESSIONAL LANE			
4. FATHER'S NAME			First Middle Last			5. MOTHER'S MAIDEN NAME			First Middle Last						
WILLIAM CUMMISKEY						REGINA			RYAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS						
			498-16-5634			ROBERT E. CHRISTIAN			HUSBAND						
B. CAUSE OF DEATH (Enter only one cause per line for a, (b) and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia due to aspirated food</u> DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
												Sudden			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE <input type="checkbox"/>				21b TIME OF INJURY Month Day Year				21c HOW INJURY OCCURRED Enter nature of injury in Part 1 or Part 2 item 18							
1234 P.M. 8/18/68								When eating + drinking aspirated food.							
21d INJURY OCCURRED				21e PLACE OF INJURY At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD No City or town County State							
WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input checked="" type="checkbox"/>				home				259 Congressional Lane Rockville Montgomery Md							
22a I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
22b DATE SIGNED				22c ADDRESS (Street, city, town, or county)											
Aug 19, 1968															
23a BURIAL CREMATION REMOVAL Specify				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or town County) State			
Burial-transit				8/20/1968								Houston Texas			
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE							
1331 Rockville Pike				DATE AUG 22 1968				John Carlos Judge							
Tyson Wheeler Funeral Home Rockville, Md.															

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR 4 5ME 5  
DM REV 1 68

Items 18-22a Film 405 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86

DECEASED NAME Type or Print		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
John Waverly Claggett Jr.					8 24 1968					M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE in year months	7a MONTH	YEAR	2c DATE PRONOUNCED DEAD		Month	Day
Male	Negro	2/19/21		47			8 24 1968			7:30 P
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY		
Maryland		U.S.A.				Montgomery		landscaping		
10 CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		2a S.A. OCCUPATION Kind of work done during most of working life even if retired.		12b KIND OF BUSINESS OR INDUSTRY				
en route to hospital				landscaper		landscaping				
3a S.A. RESIDENCE Where deceased lived		13c CITY OR TOWN		3d HOUSE Y IN 15'		3e STREET AND NUMBER				
Maryland		Montgomery		Sandy Spring		18404 Brooke Road				
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO		17 INFORMANT		Records
John Waverly Claggett		Sarah Francis Hopkins		no				Montgomery General Hospital, Olney, Md.		ADDRESS
18 CAUSE OF DEATH (File only one cause per line for a (b) and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Peritonitis - Severe		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		24 hrs.		
560.2		DUE TO, OR AS A CONSEQUENCE OF		Perforation of ileum				24 hrs.		
Conditions if any which gave rise to immediate cause or stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF		Volvulus of ileum				48 hrs.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		57								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
2d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY At home farm street factory office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a I certify that I took charge of the remains described above. He died on		Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and on my opinion		death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b DATE SIGNED		8/24/1968				
EXAMINER'S NAME Type		Belden R. Reap, M. D.		DEPUTY MEDICAL EXAMINER		22c SIGNATURE				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION City or Town		County		State
Burial		8-28-68		Ash Memorial		Sandy Spring MD				
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REC'D BY S.S. CONF. REL.				
Richard J. Kinner				DATE		AUG 28 1968				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

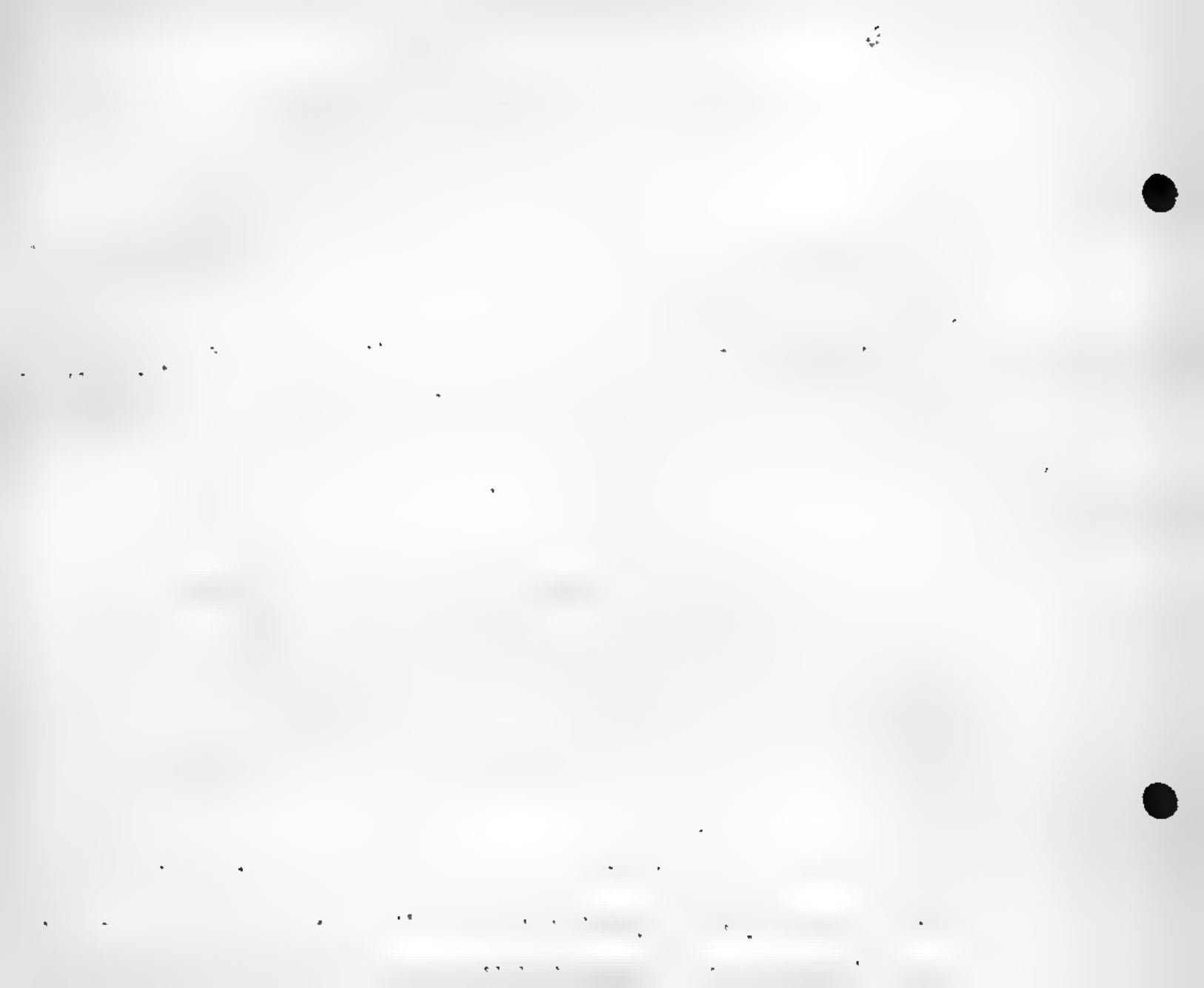
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.

VR A15  
30M REV 1-68

11680

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last <u>Mr. Charles A. Clements Jr.</u>			2a. DATE OF DEATH Month Day Year <u>Aug 18 1968</u>			2b. HOUR <u>2:40 p.m.</u>	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>6/18/86</u>		6. AGE (in years last birthday) <u>82</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery Co.</u> Md.	
10. CITY OR TOWN OF DEATH <u>Silver Spring, Md.</u>		NAME OF HOSPITAL OR INSTITUTION (give street address) <u>Holy Cross Hospital</u>		2a. USUAL OCCUPATION Kind of work done during most of working life (even if retired) <u>Deputy Clerk</u>		2b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE Where deceased lived, if institution: Residence before admission STATE <u>Md.</u>		13b. COUNTY <u>Mont. Co.</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>567 Dennis Ave.</u>		14. FATHER'S NAME First Middle Last <u>Charles A. Clements, Sr.</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Marie L. McGraw</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> or unknown; <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO. <u>220-40-5745A</u>		17. INFORMANT <u>Charles A. Clements III</u>		Address <u>1719 Dublin Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thromboses recurrent</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause, or, stating the underlying cause lost, (c) <u>disease</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIB. TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>✓</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
22a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC.		22c. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (th's hospital) attended the deceased from <u>Aug. 3 1968</u> to <u>Aug 18 1968</u> that (I) (we) lost the deceased alive on <u>Aug 18 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (did not) view the body after death							
22b. SIGNATURE <u>Raymond Bradshaw, M.D.</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Aug. 18, 1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, Md.</u>				22e. ADDRESS <u>345 University Blvd., W. Silver Spring, Md.</u>			
23a. BURIAL CREMATION REMOVAL Specified <u>Burial</u>		23b. DATE <u>August 22, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Montg. Md.</u>	
24. FUNERAL HOME <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>8434 Ga., Ave. S.S., Md.</u>				DATE <u>AUG 22 1968</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1168										MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)					First Middle Last					2a DATE OF DEATH Month Day Year					2b HOUR				
Augustus					William					COCKRELL					August 9 Day 68 Year 605A M				
3 SEX					4 RACE					5 DATE OF BIRTH					6 AGE (In years last birthday)				
Male					Caucasian					8 Jan. 1899					69 YRS.				
7a BIRTHPLACE (State or foreign country)					7b CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH				
Florida					USA										Montgomery Md.				
10 CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (Not in hospital give street address)					12a U.S.A. OCCUPATION (Kind of work done during most of work life even if retired.)					12b KIND OF BUSINESS OR INDUSTRY				
Bethesda					Naval Hospital					U. S. Marine Corps									
13a USUAL RESIDENCE Where deceased lived, if institution Residence before admittance, STATE					13b COUNTY					13c CITY OR TOWN					13d INSIDE CITY INDEX? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
Maryland										Bethesda					407 Hanover St.				
14 FATHER'S NAME First Middle Last					15 MOTHER'S M A D E M NAME First Middle Last														
Augustus					William Cockrell					Phyllis					Knox				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give branch and date of discharge)					16b SOCIAL SECURITY NO.					17 INFORMANT					Address				
Yes NW 1 & II					572 38 0152					Fredericksburg Virginia					Mrs. Constance B. Cockrell, 407 Hanover St.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Exsanguination secondary to carcinoma of floor of mouth</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					22 HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)									
23a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					23b PLACE OF INJURY (AT HOME, FARM, STREET, OFFICE BUILDING, ETC.)					23c LOCATION Street or R.F.D. No. City or Town County State									
										520A					605 9 Aug. 19 68 to 605 9 Aug. 19 68				
22a I certify that (X) (this hospital) attended the deceased from saw the deceased a ve on 9 Aug. 19 68, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we, ( ) (did not) view the body after death																			
22b SIGNATURE <u>K. R. Matheis</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>															22c DATE SIGNED 9 Aug. 1968				
22d PHYSICIAN'S NAME, TYPE K. R. MATHEIS, M. D. 22e ADDRESS Naval Hospital, Bethesda, Md.																			
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE					23c NAME OF FUNERAL HOME OR CREMATORY					23d LOCATION (City or Town) (County) (State)				
Cremation					8-10-68					J. William Lee's Sons Co.					Washington D.C.				
24 FUNERAL DIRECTOR					J. William Lee's Sons Co.					D.C.					25a REC'D BY REGISTRAR 25b DATE AUG 13 1968				
4th and Massachusetts Ave., N.E. Washington																			

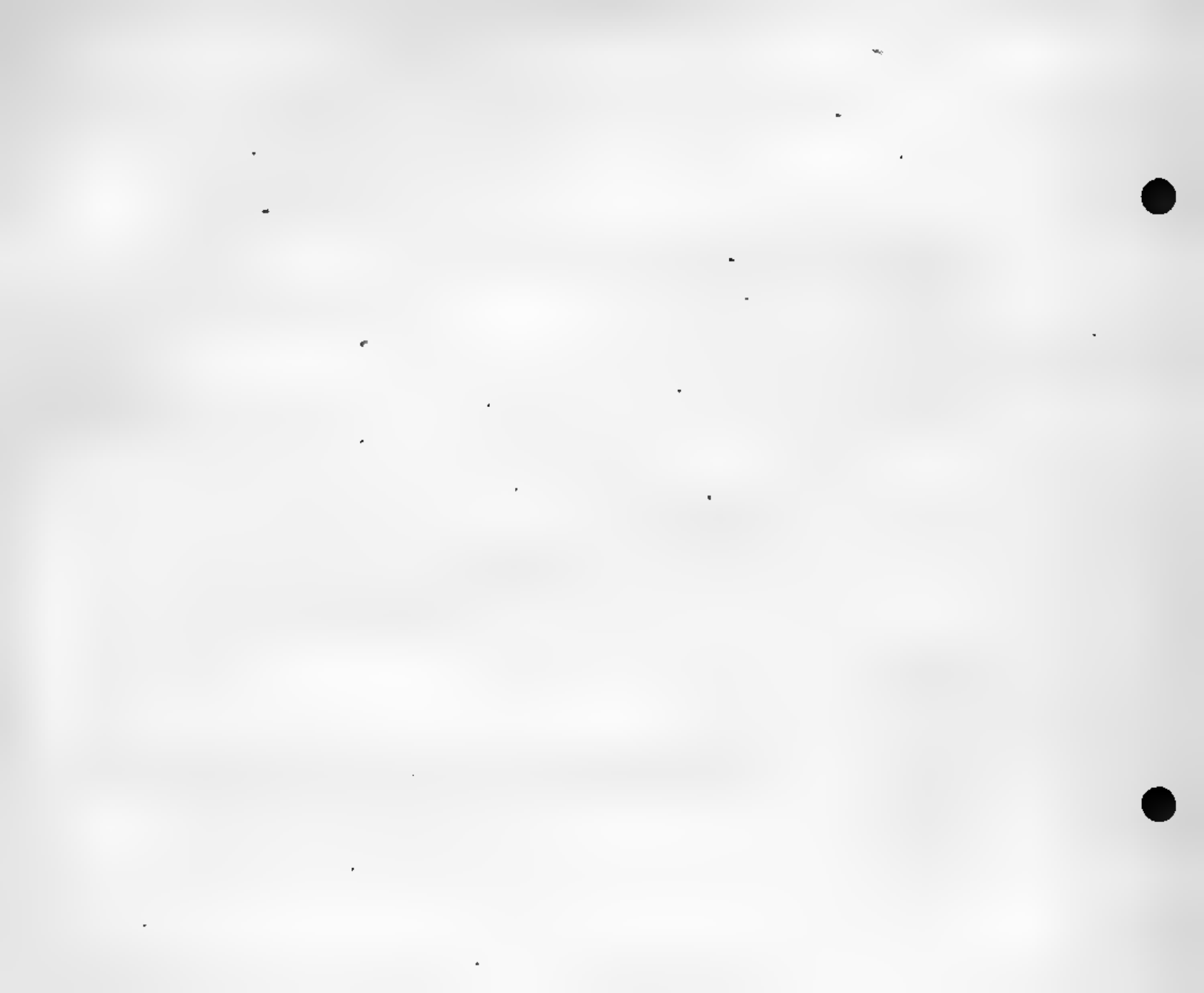




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA FORM 100-101  
300A REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
11682 CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print) <b>Keithryn Elizabeth Cogswell</b>						2a. DATE OF DEATH Month <b>8</b> Day <b>23</b> Year <b>1968</b>			2b. HOUR <b>3:45 PM</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>12-27-95</b>			6 AGE (in years last birthday) <b>72 YRS</b>		7 IF UNDER 1 YEAR MONTHS DAY		8 IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <b>DC</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>							
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Washington San &amp; Hosp Hspt</b>				12a. Usual OCCUPATION (Kind of work done during most of working life even if retired)					
13a. Usual RESIDENCE Where deceased lived, if admission) STATE <b>Md</b>				13b. RESIDENCE before 7th COUNTY <b>Prince Georges</b>				13c CITY OR TOWN <b>Lanham</b>		13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>7609 Fontainebleau Dr.</b>	
14 FATHER'S NAME First <b>Fmnk</b> Middle <b>Burns</b> Last <b>Mary</b>				15 MOTHER'S MAIDEN NAME First <b>Parris</b> Middle <b>Parris</b> Last <b>Parris</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO <b>213-42-8474</b>				17 INFORMANT <b>Hospital chart</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>158C</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive pulmonary disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Chronic obstructive pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF (d) <b>Chronic obstructive pulmonary disease</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>15A</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING (If either, notify medical examiner) <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 8.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/16</b> 19 <b>65</b> to <b>8/23</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>8/23</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE <b>Charles Judge</b>				22c. DATE SIGNED <b>8/24/68</b>				22d. PHYSICIAN'S NAME (Type) <b>Charles Judge</b>					
22e. ADDRESS <b>821</b>				22f. DEGREE <b>MD</b>									
23a. B.R.A. CREMATION, REMOVAL, SPECIAL				23b. DATE <b>8-27-68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>					
23d. LOCATION City or Town County State <b>4000 Suitland Rd. Pr. Geo Md.</b>				23e. FUNERAL DIRECTOR <b>Robert L. Wilhelm Fun.</b>									
23f. ADDRESS <b>4308 Suitland Rd.</b>				23g. REC'D BY REGISTRAR <b>AUG 30 1968</b>				23h. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate, writing the word "pending" in pencil. Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11685

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			Month	Day	Year	2b HOUR
LILLIAN E. Collins						8 2 1968			9:53			
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	21. DATE PRONOUNCED DEAD			Month	Day	Year	2d HOUR
FEMALE	WHITE	12/9/93	82 7/4 YRS			8 2 1968			9:53			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md			
Morrisson Ill.		USA				Montgomery						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION Kind of work done			12b KIND OF BUSINESS OR INDUSTRY			
Silver Spring			Holy Cross hospital			domestic housewife			domestic home			
3a STATE (where deceased lived 1 year before death)			13b COUNTY			3d INSIDE CITY LIMITS?			3e STREET AND NUMBER			
Maryland			Montgomery			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			320 Verling Lr. SSMd.			
4 FATHER'S NAME			5 MOTHER'S M maiden name									
Peter ? Johnson			Lillie ? McGilvary									
6a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			6b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS			
no			218-38-8709			daughter Mrs. Lewis G. Foster			320 Verling Dr.			
B. CAUSE OF DEATH (Enter only one cause per part (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4129 Acute Coronary Insufficiency												
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)												
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a NEXT REASON CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month Day Year P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18.)				
				19								
21d INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that I took charge of the remains described above and held on death resulted from natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
22b DATE SIGNED				22c DATE SIGNED				22d DATE SIGNED				
Aug. 3, 1968				Aug. 3, 1968				Aug. 3, 1968				
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				ASSISTANT MEDICAL EXAMINER				
Belden R. McAP M.D.												
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (If different from above)				
23a BURIAL CREMATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION City or Town County State
Burial				Aug. 5, 1968				Gate of Heaven Cemetery				Silver Spring, Maryland
24 FUNERAL DIRECTOR				25a RECD BY REGISTRAR				25b REGIS. EX. SIGNATURE				
J. Pumphrey, Inc. Silver Spring, Md.				DATE AUG 7 1968				Charles Judge				



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

11684

DECEASED NAME (Type or print) <b>Marie Louise Conklin</b>			2a. DATE OF DEATH Month <b>Aug</b> Day <b>10</b> Year <b>1968</b>			2b. HOUR <b>2:58</b>	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>March 1, 1899</b>		6 AGE in years <b>69</b> YRS MONTHS DAYS	7. UNDER 1 YEAR HOURS MIN.		
8a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		8b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b> Md.	
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban</b>		12a. USJA. OCCUPATION, Kind of work done during most of working life, even if retired <b>Secretary</b>		2b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>	
3a. USJA. RESIDENCE Where deceased lived (admission) STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <b>John B.</b> Middle <b>Calhoun</b> Last <b>Conklin</b>		15 MOTHER'S MAIDEN NAME First <b>Josephine</b> Middle <b>Tolley</b> Last <b>Conklin</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>220-54-2098</b>		17 INFORMANT <b>Dr. J. H. Conklin</b>			
18 CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Culprit was a car accident</b> <b>4120</b> Conditions (any which gave rise to immediate cause (a), stating the underlying cause) (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial infarction</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>Aug 14, 1968</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Myocardial infarction</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home - farm - street - factory - office building - etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1962</b> to <b>Aug 1968</b> , that (I) (we) last saw the deceased alive on <b>6 Aug 1968</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death							
22b. SIGNATURE <b>Paul J. Nore</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11 Aug 68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Paul J. Nore</b>		22e. ADDRESS <b>3201 Randolph Rd Rockville Md</b>					
23a. BURIAL, CREMATION, REMOVAL, SQUITY <b>buried</b>		23b. DATE <b>Aug 14, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Md.</b>	
24. FUNERAL DIRECTOR <b>James E. Humphrey, Inc.</b>		24a. ADDRESS <b>1034 Avenue</b>		25a. REC'D BY REGISTRAR <b>AUG 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>James E. Humphrey</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR 5.4  
30M REV 68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) <b>Joseph</b> <b>Connors</b>						2a DATE OF DEATH Month <b>8</b> Day <b>21</b> Year <b>68</b>			2b HOUR <b>7:20 PM</b>			
3 SEX <b>Male</b>		4 RACE <b>W.</b>		5 DATE OF BIRTH <b>12-13-1888</b>			6 AGE (In years last birthday) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS <b>8</b> DAYS <b>21</b>		IF UNDER 24 HRS. HOURS <b>21</b> MIN <b>00</b>	
7a BIRTHPLACE (State or foreign country) <b>Ireland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Montgomery</b>					
10 CITY OR TOWN OF DEATH <b>Rockville, Md</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Patoma Valley Nursing Home</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carpenter</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Building</b>				
13a U.S.A. RESIDENCE (Where deceased lived if in institution Residence before admission) STATE <b>Penna</b>				13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Poyersford</b>		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
4 FATHER'S NAME First <b>Joseph</b> Middle <b>Connors</b> Last <b>Connors</b>				5 MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Connors</b> Last <b>Connors</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give year or dates of service)				6b SOCIAL SECURITY NO		17 INFORMANT <b>Dr James J. Connors</b>			Address <b>Bethesda, Md Rt. 8014 Greenacres</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ADVANCED RHEUMATOID ARTHRITIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>1210</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>43 YEARS</b>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ASHD. W/ OLD MYOCARDIAL INFARCTION</b>												
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State		
22a I certify that (I) (this hospital) attended the deceased from <b>MAY 9, 1968</b> , to <b>AUG 21, 1968</b> , that (I) (we) last saw the deceased alive on <b>AUG. 21, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d) (did not) view the body after death												
22b SIGNATURE OF PHYSICIAN <b>Robert C. Daddario MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <b>8/21/68</b>				
22d PHYSICIAN'S NAME (Type) <b>ROBERT C. DADDARIO</b>				22e ADDRESS <b>3413 CEDAR LAVE BETHESDA</b>								
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>8-26-68</b>		23c NAME OF CEMETERY OR REMATORY <b>St. ANN's Cemetery</b>			23d LOCATION City or Town <b>Phoenixville, Penna.</b>		County (State)			
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Maryland</b>		25a REC'D BY REG. STR. <b>AUG 23 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>				





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

M.D. 4-1-64										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
11687										MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or Print) <b>Patricia Lee Cook</b>					2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 8 Day 30 Year 1968 11:10					2b HOUR														
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>10-23-32</b>		6 AGE (In years last birthday) <b>35</b> YRS		7a BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>Amer.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>		2c DATE PRONOUNCED DEAD Month 8 Day 30 Year 1968 11:10		2d HOUR						
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>					11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Wash. San &amp; Hospital</b>					12 US. AL. OCCUPATION (Kind of work done during most of working life even if retired) <b>Disabled from JHAPL</b>					13a STREET AND NUMBER <b>7401 New Hampshire Ave #908</b>									
13a USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>					13b COUNTY <b>PG</b>					13c CITY OR TOWN <b>Hyatt</b>					13d YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
14 FATHER'S NAME First Middle Last <b>Charles Hunter</b>					15 MOTHER'S MAIDEN NAME First Middle Last <b>Edith Burton</b>					16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>NO</b>					16b SOCIAL SECURITY NO. <b>577-42-3056</b>					17 INFORMANT <b>Hosp record</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE, a) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Salicylate overdose, self administered</b> DUE TO, OR AS A CONSEQUENCE OF b) <b>myocardial infarction</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month Day Year <b>6/29 1968</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18) <b>Deceased, in rescue, took overdose of salicylate</b>														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT HOME <input type="checkbox"/>					21e. PLACE OF INJURY (At home, arm street, factory office building, etc.) <b>Home</b>					21f. LOCATION Street or R.F.C. No. City or Town County State <b>Hyattsville Fr. Geo. Md.</b>														
22a I certify that I took charge of the remains described above. He died Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																								
ACTUAL SIGNATURE <b>Belden R. Reap</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					ASS STANT MEDICAL EXAMINER <input type="checkbox"/>					22b DATE SIGNED <b>Aug. 30, 1968</b>									
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					ADDRESS (City, County, State) <b>Washington Nat Cemetery Suitland Md</b>														
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE <b>9-3-68</b>					23c NAME OF CEMETERY OR CREMATORY <b>Washington Nat Cemetery Suitland Md</b>					23d LOCATION City or Town County State									
24 FUNERAL DIRECTOR <b>Reap Funeral Home Wash D.C.</b>					25a RECD BY REGISTRAR <b>SEP 4 1968</b>					25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>														



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
DOUGLAS A. COOKE						Month Day Year		19 UNK M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. MONTHS	8. DAYS	9. HOURS	10. MIN	2c DATE PRONOUNCED DEAD	2d HOUR
male	white	2/14/1931	37 YRS					Month Day Year	11:50 A.M.
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
HAWAII			USA				Montgomery Md.		
10 CITY OR TOWN OF DEATH			1 NAME OF HOSPITAL OR INST. TO WHICH (If not in hospital give street address)			2a USUAL OCCUPATION Kind of work done during most of work life (even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Rockville			218 W. Montgomery Ave.			NONE			
13a USUAL RESIDENCE (Where deceased lived continuously on Residence before death)			3b CITY OR TOWN		3c INSIDE CITY LIMITS?		3d STREET AND NUMBER		
Maryland			Montgomery		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		218 W. Montgomery Avenue		
14 FATHER'S NAME First Middle Last			5 MOTHER'S MAIDEN NAME First Middle Last						
DOUGLAS A. COOKE			McLEAN						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			6b SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
NO			NO		R12-42 8526 CHESTNUT LODGE RECEIPTS				
8 CAUSE OF DEATH (Enter only one cause per line for a, b, and c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE: Unetermined due to advanced decomposition									
DUE TO OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause or prolonging the underlying cause									
DUE TO OR AS A CONSEQUENCE OF									
DUE TO OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
1955									
19a DATE OF OPERATION			19b CONDITION OR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
2a EXTERNAL CAUSE WAS PRIMATE <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			2b TIME OF INJURY Month Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 2 or Part 2 Item 8)			
			19 P.M.						
2d INJURY ON WHEEL			21a PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21b LOCATION Street or R.F.D. No City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED			
Werner U. Spitz M.D.						8/13/68			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
			ADDRESS Street City Town or County						
23a BURIAL CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION City or Town County State
CREMATION AUG 15, 1968 CEDAR HILL									DUNLAP, PG, MD
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
TYSON WHEELER ROCKVILLE, MD.			AUG 19 1968			Charles Judge			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal and in any event within 72 hours after death.

11688

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME Type or Print) <b>SALVATORE DOMINIC COSTELLA</b>				1a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Aug.</b> Day <b>10</b> Year <b>1968</b>				2a HOUR OF DEATH <b>1:00 P.M.</b>	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>5-31-33</b>	6 AGE (In years (or birthday) <b>35</b> YRS.	7 UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	8 UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c DATE PRONOUNCED DEAD Month <b>Aug.</b> Day <b>10</b> Year <b>1968</b>		2d HOUR <b>2:05 P.M.</b>	
7a BIRTHPLACE (State or foreign country) <b>New York</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>			
10 CITY OR TOWN OF DEATH <b>Takoma Park,</b>		NAME OF HOSP. or NSTITUTION (if not in hospital give street address) <b>Wash. San &amp; Hosp.</b>		2c USAR OCCUPATION (Kind of work done during most of working life even if retired) <b>Teacher</b>		12b KIND OF BUSINESS OR INDUSTRY <b>U. of Md.</b>			
3a USAR RESIDENCE (Where deceased was born or resided before admission) STATE <b>Md.</b>		3b COUNTY <b>P.G.</b>		3c CITY OR TOWN <b>Adelphi</b>		3d INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		3e STREET AND NUMBER <b>2510 Hughes Rd.</b>	
4 FATHER'S NAME First Middle Last <b>Salvatore Costella</b>				5 MOTHER'S MAIDEN NAME First Middle Last <b>Margaret</b>					
6a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes Korea</b>				6b SOCIAL SECURITY NO		17 INFORMANT ADDRESS <b>Mrs. Lorraine Costella - Wife</b>			
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxiation due to</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last <b>strangulation by hanging,</b> (b) <b>self-inflicted.</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF 1c <b>self-inflicted.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a DATE OF OPERATION				9b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PR MARY OR CONTR BUTING CAUSE OF DEATH		2 b TIME OF N. JRY Month Day Year <b>10:00 AM 8-10-68</b>		2 c HOW INJURY OCCURRED (Enter nature of injury and place where it occurred) <b>Deceased hanged self in basement of home.</b>					
2 d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		2 e PLACE OF IN JRY (At home farm, street, factory, etc.) <b>Home</b>		2 f LOCATION Street or R.D. No. City or Town County State <b>2510 Hughes Rd. Adelphi, Md.</b>					
22a I certify that I took charge of the remains described above. held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL EXAMINER'S NAME Type		Belden R. Reap, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <b>Aug. 10, 1968</b>			
23a BURIAL CREMATION REMOVAL specify		23b DATE <b>12 AUG 68</b>		23. NAME OF CEMETERY OR CREMATORY <b>GEORGETOWN UNIV. MED. SCH., WASHINGTON, D.C.</b>		23d LOCATION City or Town County State			
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR <b>Charles Judge</b>		25b REC'D BY REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 20 1968</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

VR 455 M4  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 12a Film 6-12-68

11689

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <b>Thatcher Randolph Cottrell</b>			2a. DATE OF DEATH Month Day Year <b>August 7 1968</b>		2b. HOUR P <b>10:59</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>6 January 1906</b>		6 AGE in years at birthday <b>62</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Montgomery</b>			10. CITY OR TOWN OF DEATH <b>Bethesda</b>		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center</b>			12a. USUAL OCCUPATION (Kind of work done during life, if at work or life even if retired) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>5101 River Road</b>
14 FATHER'S NAME First Middle Last <b>John Cottrell</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Julia Randolph</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NE</b>		16b. SOCIAL SECURITY NO		17 INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, NIH, Bethesda, Md. 20014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a) <b>Cardiac Arrest</b> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause, (a) stating the underlying cause last (b) <b>Lymphosarcoma</b> DUE TO OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>2 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1, (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
22a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME - HOME, STREET, FACTORY, OFFICE BUILDING, ETC.)		22c. LOCATION Street or R.F.D. No City or Town County State	
22d. I certify that (this hospital) attended the deceased from <b>18 July 1968</b> to <b>7 August 1968</b> , that (I) (we) lost saw the deceased alive on <b>7 August 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22e. SIGNATURE <b>Mark E. Oren, M.D.</b>		22f. PHYSICIAN'S NAME (Type) <b>Mark E. Oren, M.D.</b>		22g. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>	
22h. DATE SIGNED <b>8 August 1968</b>		22i. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMAINS <b>Cremation 8-9-68</b>		23b. DATE <b>8-9-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	
23d. LOCATION, City or Town, County, State <b>Suitland, Maryland</b>		23e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
24 FUNERAL DIRECTOR <b>ROBERT A. PIMPHREY, Bethesda, Maryland</b>		24a. ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





CERTIFICATE OF DEATH

11690

DECEASED NAME (Type or print) <b>Edward Elijah Covington</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>1968</b>			2b. HOUR <b>11 45 PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>8/21/92</b>		6 AGE in years last birthday <b>75</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery Co.</b>	
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Wash. Sun Hosp.</b>		2a. USUAL OCCUPATION (Kind of work done during most of work ng. life, even if retired) <b>Farmer</b>		2b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL RESIDENCE (Where deceased lived at institution Residence before admission) STATE <b>MD.</b>		10b. COUNTY <b>Green Gages</b>		13a. CITY OR TOWN <b>Centerville</b>		13b. INSURANCE COMPANY <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
14 FATHER'S NAME First <b>Henry</b> Middle <b>Covington</b> Last <b>Reed</b>		5 MOTHER'S MAIDEN NAME First <b>Killian</b> Middle <b>Reed</b> Last <b>Reed</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give unit and dates of service)		16b. SOCIAL SECURITY NO. <b>215 36-2262</b>		17 INFORMANT <b>Sarah Crouke</b> Address <b>1235 Overlook Dr. SS. Md.</b>			
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CVA</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>General arteriosclerosis</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cor. yrd</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR <b>AM</b> Month <b>Day</b> Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (A HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 21, 1968</b> to <b>Aug 2, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do), (did not) view the body after death							
22b. SIGNATURE <b>R. W. Sandstrom</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Aug 2, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>R. W. Sandstrom MD</b>				22e. ADDRESS <b>7701 Canal Ave Takoma Park Md</b>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <b>AUG. 6</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHICSTERFIELD</b>		23d. LOCATION City or Town (County) State <b>CENTREVILLE G.A. MD.</b>	
24. ELABORATE DIRECTOR <b>Edgar Lane Church Hill Md.</b>				25a. REC'D BY REGISTRAR <b>AUG 12 1968</b>		25b. REGISTERED LOCATION <b>John</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the physician. Pages 1, 2, 3, and 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1, 2, 3, and 4 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Baltz notified - not notified

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <i>Oliver C. Cox</i>						2a. DATE OF DEATH <i>Aug 2 1968</i>			2b. HOUR <i>PM</i>		
3 SEX <i>male</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>11/16/187</i>		6. AGE (Years last birthday) <i>86</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban Hospital</i>		2a. USUAL OCCUPATION (Kind of work done during most of workable week if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
3a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>D.C.</i>		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3115 Nebraska Ave</i>			
4. FATHER'S NAME First <i>Philip</i> Middle <i>Cox</i> Last <i>Cox</i>				15. MOTHER'S MAIDEN NAME First <i>Ellen</i> Middle <i>Moores</i> Last <i>Moores</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no. of unknown) <i>NO</i>				16b. SOCIAL SECURITY NO <i>599-60-2527</i>		17 INFORMANT <i>GRACE P. COX-3115 NEBRASKA AVE NW</i> Address <i>WASH. DC</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Leukemia relapse</i> <i>177X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Carcinoma metastatic to spine</i> DUE TO OR AS A CONSEQUENCE OF (c) <i>Secondary hyperparathyroidism</i> 177X										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 wks</i> <i>5 1/2 mo's</i> <i>in few</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>177X</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)							
22a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		22b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		22c. LOCATION Street or RFD No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>MARCH 1968</i> to <i>AUG 2, 1968</i> , that (I) (we) lost saw the deceased alive on <i>8/2</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>M.F. Weingarten</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>8/2/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>M.F. Weingarten</i>				22a. ADDRESS <i>5558 14th Avenue St C.C. MD</i>							
23a. BURIAL CREMATION REMOVAL <i>CREMATION</i>		23b. DATE <i>8/4/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CEDARHILL CREMATORY</i>				23d. LOCATION (City or Town) (County) (State) <i>SUITLAND MD</i>			
24. FUNERAL DIRECTOR <i>JOE SAWLERS-SONS</i>				ADDRESS <i>WASH. DC</i>		25a. REGD BY REGISTRAR DATE <i>AUG 7 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

11692

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

DECEASED NAME (Type or print) <b>Ralph Merle Cox</b>		2a. DATE OF DEATH Month <b>Aug</b> Day <b>17</b> Year <b>68</b>		2b. HOUR <b>12:35 PM</b>
3 SEX <b>M</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>4-24-'84</b>	6 AGE (in years last birthday) <b>84 YRS.</b>	IF UNDER 1 YEAR MONTHS <b>3</b> DAYS <b>23</b>
7a. BIRTHPLACE (State or foreign country) <b>Mo.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Montgomery</b> Md	
10 CITY OR TOWN OF DEATH <b>Rockville Md</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Potomac Valley Nursing Home</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>Rancher</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. USUAL RESIDENCE (Where deceased lived at institution Residence before admission) STATE <b>Md</b>	13b. COUNTY <b>Montgo.</b>	13c. CITY OR TOWN <b>Springs</b>	3e. STREET AND NUMBER <b>8810 Maywood Avenue</b>	
4 FATHER'S NAME First Middle Last <b>Noah Cox</b>		5 MOTHER'S MAIDEN NAME First Middle Last <b>Martha Ann Hurst</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>Not furnished</b>	17 INFORMANT <b>Daughter</b> <b>Dorothy C. Donnelly</b> Address <b>Same as Item 13.</b>	
18 CAUSE OF DEATH (Enter on y one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE a) <b>Congestive Heart Failure, Acute</b> DUE TO, OR AS A CONSEQUENCE OF Conditions (any which gave rise to immediate cause, or stating the underlying cause) lost (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>Several years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>4200</b>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)	21b. TIME OF INJURY HOUR AM Month Day Year <b>PM 19</b>	21c. HOW INJURY OCCURRED Enter nature of injury in Part 1 or Part 2 Item 18)		
22a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	22b. PLACE OF INJURY (AT HOME, ARM, IRLT, FACTORY, OFFICE, BUILDING, ETC.)	22c. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I, (this hospital) attended the deceased from <b>1960 to Aug 17 1968</b> that (I) (we) last saw the deceased alive on <b>Aug 17 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (view) view the body after death				
22b. SIGNATURE <b>James V. Egan</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>8/17/68</b>	
22d. PHYSICIAN'S NAME, Type <b>JAMES V. EGAN</b>	22e. ADDRESS <b>5413 Cedar Lane Bethesda, Maryland</b>			
23. BURIAL, CREMATION, REMOVAL, etc. <b>Burial</b>	23b. DATE <b>8-20-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>	23d. LOCATION (City or Town County State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>	ADDRESS <b>7557 Wisconsin Rd</b>	25a. RECEIVED BY REGISTRAR <b>DATE AUG 23 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11693

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

700

CERTIFICATE OF DEATH

DECEASED NAME (Type or print) <b>John James Crumbaugh</b>			2a. DATE OF DEATH Month <b>Aug.</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR <b>6:15 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>Aug. 17, 1885</b>		6. AGE in years (lost to day) <b>83</b> YRS		7. UNDER 1 YEAR MONTHS <b>13</b> DAYS <b>13</b> HOURS <b>13</b> MIN	
7a. BIRTHPLACE (State or foreign country) <b>Wilmington, Del.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery, Md.</b>			
10. CITY OR TOWN OF DEATH <b>Kensington, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Kensington Gardens San.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Mining Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Du Pont</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>Wash.</b>		13c. STREET AND NUMBER <b>800-4th St. S.W.</b>			
14. FATHER'S NAME First <b>John</b> Middle <b>J.</b> Last <b>Crumbaugh</b>			15. MOTHER'S M.A.D.E.N NAME First <b>Mary</b> Middle <b>Develin</b> Last <b>WASH., D.C.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or defense service) <b>WWI</b>		16b. SOCIAL SECURITY NO. <b>WASH.</b>		17. INFORMANT <b>JOHN CRUMBAUGH-Son - 800 4th St S.W.</b>			
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a), <b>congestive heart failure -</b> DUE TO, OR AS A CONSEQUENCE OF (b), <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c), <b>4221</b> Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BEWEEN ONSET AND DEATH <b>2 days</b> <b>yes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a), <b>Generalized arteriosclerosis, Chronic brain syndrome</b>							
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from <b>1949 to 30 Aug. 1968</b> , that (I) (we) last saw the deceased alive on <b>29 Aug. 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Horace W. Bernton, M.D.</b>				22c. DATE SIGNED <b>30 Aug 68</b>			
22d. PHYSICIAN'S NAME (Type) <b>HORACE W. BERTON</b>				22e. ADDRESS <b>4743 BRADLEY BLVD., CHEVY CHASE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL, SPECIFY <b>Burial</b>		23b. DATE <b>9/3/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg Prince Georges Md.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gaylor's Sons 5130 Misc. Av. N. Wash.</b>				25a. REC'D BY REGISTRAR <b>SEP 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the bar of transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA 5-4  
30M REV 7-68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
Helen			M.		CURREN		Aug			1968		M
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE in years last birthday		7 NUMBER YEAR MONTHS DAYS	
FEMALE			WHITE			9/4/89			78 YRS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			10
ILLINOIS			U.S.A.						MONTGOMERY			MD.
11 CITY OR TOWN OF DEATH			12a. USUAL OCCUPATION (If not at work during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY						
BETHESDA			SUBURBAN			HOUSEWIFE						
13a. USUAL RESIDENCE (Where deceased lived 1 institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER
MARYLAND			MONTGOMERY			BETHESDA						5807 WYNGATE DR.
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME									
JOHN			HICKEY			ANNA						HOWARD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT			Address			
			219-54-7831			Alice Hickey - Sister - SAME						
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Mellitus - Ketoacidosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pernicious anemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>last</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 years	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>XAO</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CHIEF CAUSE OF DEATH <input type="checkbox"/> (If other notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 3 or Part 2 Item 18.)						
22a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, ARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			22c. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1967 to 1968, that (I) (we) lost saw the deceased alive on 1 Aug 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
									1 Aug 68			
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
JOSEPH S. DAUM			4977 Patton Lane Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			8-3-68			Holy Sepulchry			Worth Ill			
24. FUNERAL DIRECTOR			25a. RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Robert A Pumphrey			7557 Wisconsin Ave Bethesda, Md			DATE AUG 5 1968			Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death cert be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11695

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month 8 Day 15 Year 68			2b. HOUR 684:30P			
William			Irvine			Darter						
3. SEX Male		4. RACE White		5. DATE OF BIRTH 4/29/05			6. AGE (in years last birthday) 63 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery Gen. Hosp.			12a. USUAL OCCUPATION Kind of work done during most of working life even if retired Store Mgr.			12b. KIND OF BUSINESS OR INDUSTRY Mercantile				
3a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3374 Chiswick Court		
4. FATHER'S NAME First Middle Last Lewis J. Darter			15. MOTHER'S M.A.D.E.N. NAME First Middle Last Susan -- Irvine									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown)		16b. SOCIAL SECURITY NO. 362 10 2023		17. INFORMANT Medical Records		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral metastases DUE TO OR AS A CONSEQUENCE OF (b) Carcinoma of Lung DUE TO OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 1 1/2 yrs.		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION 8/15/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Feeding Gastrostomy			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING? <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 7/30/68, 19 to 8/15, 1968, that (I) (we) last saw the deceased alive on 8/15/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (saw) view the body after death												
22b. SIGNATURE Richard A. Yates, M.D.					DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8/15/68			
22d. PHYSICIAN'S NAME (Type) Richard A. Yates, M.D.					22e. ADDRESS Old Baltimore Road, Olney, Md.							
23a. BURIAL, CREMATION, REMOVAL, SPECIFY burial/removal		23b. DATE 8/16/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven			23d. LOCATION (City or Town) (County) (State) Louisville, Kentucky					
24. FUNERAL DIRECTOR Jos. Gawler's Sons - Balt. D.C.					ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 21 1968		25b. REGISTRAR'S SIGNATURE Glenora J. J.			



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in parentheses. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and within 22 hours after death.

Items 18 & 2a Film 403 MARYLAND STATE DEPARTMENT OF HEALTH  
8-23-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11698

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11703

1 DECEASED NAME (Type or Print) <b>MARIE Z. DELLAMONICA</b>			2a DATE KNOWN OF DEATH Month <b>8</b> Day <b>11</b> Year <b>68</b>			2b HOUR <b>9:10</b>				
3 SEX <b>F</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>4-5-94</b>	6 AGE <b>74</b>	7 IF MARRIED MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month <b>8</b> Day <b>11</b> Year <b>68</b>			2d HOUR <b>9:10</b>		
7a BIRTHPLACE (State or foreign) <b>Washington D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9 COUNTY OF DEATH <b>Montgomery</b>			2e KIND OF BUSINESS OR INDUSTRY <b>same</b>			
10 CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>11223 Ashley Drive</b>			2a SOCIAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Baby Sitter</b>			2b KIND OF BUSINESS OR INDUSTRY <b>same</b>		
3a US A. RESIDENCE (Where deceased had instruction on Residence before admission) STATE <b>MD.</b>		13b COUNTY <b>MONT.</b>		CITY OR TOWN <b>ROCKVILLE</b>		3c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>11223 ASHLEY DR.</b>		
14 FATHER'S NAME <b>JOHN H. HANSON</b>			15 MOTHER'S MAIDEN NAME <b>ALICE V. LAMPKIN</b>			16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>NO</b>			17 INFORMANT ADDRESS <b>578-46-4055A George L. Beach 11223 Ashley Dr.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute ruptured abdominal aortic aneurysm</b> 4412 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <b>DUE TO OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO OR AS A CONSEQUENCE OF</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR COMPLICATION GIVEN IN PART 1: 451x										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF DEATH Month Day Year HOUR A.M. P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 8)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>BELDEN R. REAP</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <b>Aug. 11, 1968</b>				
EXAMINER'S NAME Type: <b>BELDEN R. REAP M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
23a BURIAL OR CREMATION <b>Burial</b>			23b DATE <b>August 14</b>			23c NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>				
23d LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>			24 FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>			25a REC'D BY REGISTRAR DATE <b>AUG 15 1968</b>				
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			25c ADDRESS <b>1331 Rockville Pike Maryland</b>							



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in plain ink, item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

VR 1575  
OM REV 7-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME Type or Print			First Middle Last			2a. DATE KNOWN OF DEATH		2b. MONTH DAY YEAR	
JAY GOULD DEMUTH						EST. MATED		8-14-68	
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE in years last birthday	IF UNDER 14 HR MONTHS DAYS		7c. DATE PRONOUNCED DEAD		7d. MONTH DAY YEAR
Fe	CAK	March 21-1896		78 YRS			8 17		68 11 17
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Md.		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		2b. KIND OF BUSINESS OR INDUSTRY	
Gaithersburg			611 N. FRED. AVE.						
3a. U.S.A. RESIDENCE (Where deceased lived at institution, residence before admission, STATE)			3b. COUNTY		3c. CITY OR TOWN		3d. HOUSE NUMBER		3e. STREET AND NUMBER
MD.			MONTGOMERY		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		611 N. Frederick Ave.
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
Susan Peter Demuth			K. Keenan			Sutton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOC. SEC. SECURITY NO.		17 INFORMANT		ADDRESS		
					For records -				
<p>8 CAUSE OF DEATH (Enter only one to use per line for a, b, and c.)</p> <p>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u></p> <p>4129 DUE TO OR AS A CONSEQUENCE OF</p> <p>(b) <u>Arteriosclerotic Heart Disease</u></p> <p>DUE TO OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause or stating the underlying cause lost</p>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. A STITCHES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS FOR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2 or Part 2 item 8)			
			P.M. 9						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home farm street factory office building, etc.)			21f. LOCATION (Street or R.F.D. No. City or Town County State)			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
<p>22a. I certify that I took charge of the remains described above and an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME TYPE			ASSISTANT MEDICAL EXAMINER			DEPUTY MEDICAL EXAMINER			
Belden R. Reap, M.D.			M.D.			Aug. 17, 1968			
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR REMATORY			23d. LOCATION (City or Town County State)
Burial			8/20/68			Providence 22 Union			Providence 22 Union Md
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REC STRAR		25b. REC STRAR'S SIGNATURE	
Ernest C. Gartner			Gaithersburg, Md.			DATE AUG 21 1968		J. Charles Judge	





MEDICAL EXAMINER'S CERTIFICATE OF DEATH

705

FOR STATE HEALTH DEPT.

11695

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files.

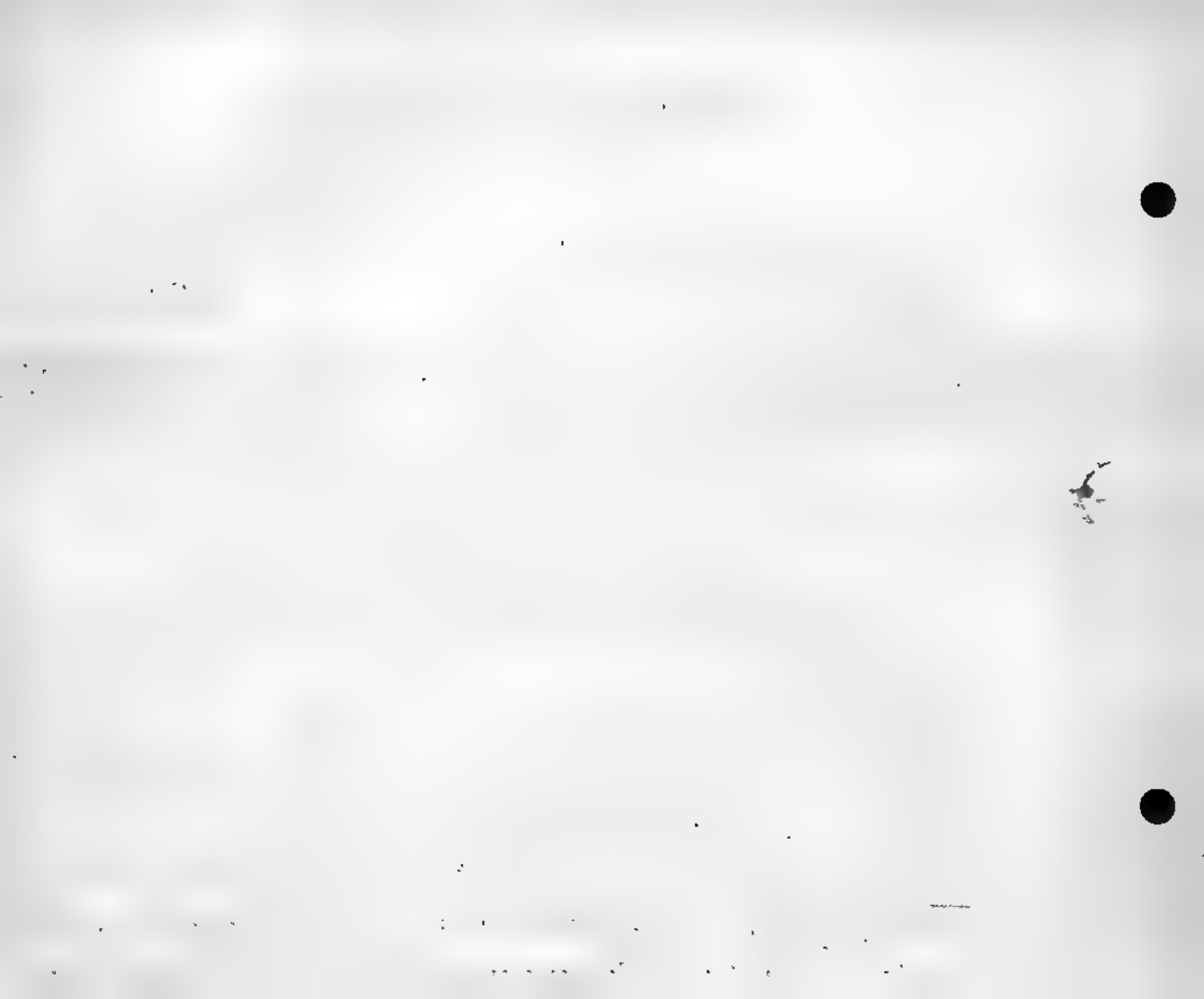
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)			First ARTIN			Middle DERBALIAN			Last DERBALIAN			2a DATE KNOWN OF DEATH EST <input checked="" type="checkbox"/> Month 8 Day 10 Year 68			2b HOUR 12:30 M				
3 SEX M		4 RACE Wh.		5 DATE OF BIRTH 04/05/18		6 AGE 11- years last birthday 50 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2L DATE PRONOUNCED DEAD Month 08 Day 10 Year 68			2d HOUR 12:30 M				
7a BIRTHPLACE (State or foreign country) Egypt				7b CITIZEN OF WHAT COUNTRY? U.A.R.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH Montgomery Md							
10 CITY OR TOWN OF DEATH Silver Spring				NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hospital								2e USUAL OCCUPATION (Kind of work done during most of own life, even if retired) Photographer				12b KIND OF BUSINESS OR INDUSTRY Self-empl			
11a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Maryland				11b COUNTY Montgomery				11c CITY OR TOWN Silver Spr				11d YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				11e STREET AND NUMBER 8502-16th Street			
4 FATHER'S NAME First YOUSSEF				Middle DERBALIAN				Last BIBIRAN				5 MOTHER'S MAIDEN NAME First KAZCNIJIAN				Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) No				16b SOCIAL SECURITY NO 579 703472				17 INFORMANT ADOP DERBALIAN				ADDRESS 65 MANOR DR NEWARK, N.J.							
18. CAUSE OF DEATH (Enter only one cause per line. Do not use "I" or "it".)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency																			
CONDITIONS if any which gave rise to immediate cause or stating the underlying cause last (b) Coronary Artery Heart Disease.																			
DUE TO OR AS A CONSEQUENCE OF																			
DUE TO OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) X 201																			
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				2b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19				2c HOW INJURY OCCURRED Enter nature of injury in Part 1 or Part 2 (item B)											
2d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				2e PLACE OF INJURY At home farm, street, factory, office building, etc.)				2f LOCATION Street or R.F.D. No City or Town County State											
22a I certify that I took charge of the remains described above. I held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE EXAMINER'S NAME Type Belden R. Keap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b DATE SIGNED Aug. 10, 1968											
23a BURIAL CREMATION R. MOVA, Spec. ly				23b DATE 8-12-68				23c NAME OF CEMETERY OR CREMATORY WASH NAT. CEM				23d LOCATION City or Town County State SUITLAND MD							
24 CENTRAL DIRECTORY W. W. Chambers				ADDRESS 1400 CHAPIN ST NW				25a REC'D BY R. C. STRAR DATE AUG 13 1968				25b REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
(Infant Boy)			De Shazor			August 8 Day 1968		5:10 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER YEAR	
Male		XXX White		August 8, 1968		YRS MONTHS DAYS		13 10 10	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION, if not in hospital		12a. USJA. OCCUPATION (Kind of work done during last 12 months, if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Washington San. & Hosp.		None		None			
13a. USJA. RESIDENCE Where deceased lived if institution Residence before admission		13b. CITY OR TOWN		13c. STREET AND NUMBER					
STATE Md.		COUNTY Mont.		Burtonsville		3208 Greencastle Road			
14. FATHER'S NAME			15. MOTHER'S M.A.D.E.N. NAME						
First Middle Last			First Middle Last						
Roy Albert DeShazor			Pamela Irene Ryan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (unknown)		None		Mr. John Ryan		Burtonsville, Md.			
				Baby & mother's charts		3208 Greencastle Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity Respiratory									
DUE TO, OR AS A CONSEQUENCE OF (b) Asbest's Syndrome								12 hrs	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ALTOPSY?		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH if either notify medical examiner		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 8-8, 1968 to 8-8, 1968, that (I) (we) last saw the deceased alive on 8-8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d) (d) (did not) view the body after death									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED			
Mitchell Woldoff, M.D.		Mitchell Woldoff, M.D.		4801 Georgia Ave. Prince Georges Co. Md.		8-8-68			
23a. BIRTHPLACE (State or foreign country)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) State			
Cremation		8-13-68		St. Lincoln Crematory		Prince Georges County, Md.			
24. FUNERAL DIRECTOR		25a. RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc.		DATE		AUG 16 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

11700

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <u>Dorothy E. Higgins</u>			2a. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1968</u>			2b. HOUR <u>9A</u> M								
3. SEX <u>F</u>		4. RACE <u>Cauc</u>		5. DATE OF BIRTH <u>11-29-24</u>		6. AGE (In years last birthday) <u>43</u> YRS.		7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		8. IF UNDER 24 HR HOURS <u></u> MIN <u></u>				
7a. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		7b. CITIZEN OF WHAT COUNTRY? <u>US</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md								
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hosp. 150 W.</u>			20. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			21. KIND OF BUSINESS OR INDUSTRY					
12a. USUAL RESIDENCE (Where deceased lived, if admission) STATE <u>MD</u>			12b. COUNTY <u>Prince George</u>			12c. CITY OR TOWN <u>Delphi</u>			12d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			12e. STREET AND NUMBER <u>1826 Metzger Rd #26</u>		
14. FATHER'S NAME First Middle Last <u>Bertram K. DuBois</u>				15. MOTHER'S MAIDEN NAME First Middle Last <u>Helen M. Clinton</u>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give unit or dates of service)				16b. SOCIAL SECURITY NO <u>578-28-5904</u>		17. INFORMANT Address <u>James L. Higgins-Item # 13</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Essential Hypertension</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>68</u> , to <u>8/30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE <u>R. T. Benack</u>				22c. DATE SIGNED <u>8/30/68</u>				22d. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>						
22e. ADDRESS <u>445 Polie Dr Wheaton Md.</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept. 3, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>				23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>						
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>		25a. REC'D BY REGISTRAR <u>SEP 4 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give me carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal. And in any event, within 72 hours after death.

11703

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

708

1 DECEASED NAME (Type or print) <b>Morris</b>		First	Middle	Last	2a DATE OF DEATH Month <b>8</b> Day <b>19</b> Year <b>68</b>		2b HOUR <b>5A</b> M
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH <b>3-21-95</b>		6 AGE (in years last birthday) <b>73</b> YRS.	
7a BIRTHPLACE (State or foreign country) <b>N.Y.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>HELY CROSS</b>		12a OCCUPATION (kind of work done during most of working life ever (if not) <b>TRUCK DRIVER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>FEED</b>	
13a U.S.A. RESIDENCE (Where deceased lived admission) STATE <b>FLORIDA</b>		13b COUNTY <b>DADE</b>		13c CITY OR TOWN <b>MIAMI</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <b>SIGMUND</b>		15 MOTHER'S MAIDEN NAME First <b>MINNIE</b>		16 ADDRESS <b>1314 MIAMI</b>		17 STREET AND NUMBER <b>PRES. MADISON HOTEL</b>	
18a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)		18b SOCIAL SECURITY NO. <b>577-36-7238</b>		19 INFORMANT <b>ANNA DOBSCHULTZ</b>		Address <b>(see p. 3)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for a) (b) and PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>myocardial infarction</b> Conditions if any which gave rise to immediate cause a) stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
22a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		22b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		22c LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> 1968 to <b>August</b> 1968, that (I) <del>last</del> saw the deceased alive on <b>8/18</b> 1968, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) (did not) view the body after death.							
22b. SIGNATURE <b>G. Linwood Gold</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/19/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>G. LINWOOD GOLD</b>		22e ADDRESS <b>7801 GA AVE SIL. SPR. MD</b>					
23a BURLA CREMATORY <b>BURLA</b>		23b DATE <b>8/28/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>KESNER ISRAEL CON</b>		23d LOCATION (City or Town, County, State) <b>Washington</b>	
24 FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>		24b ADDRESS <b>4217 9th St. N.W.</b>		25a REC'D BY REGISTRAR <b>DATE AUG 22 1968</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





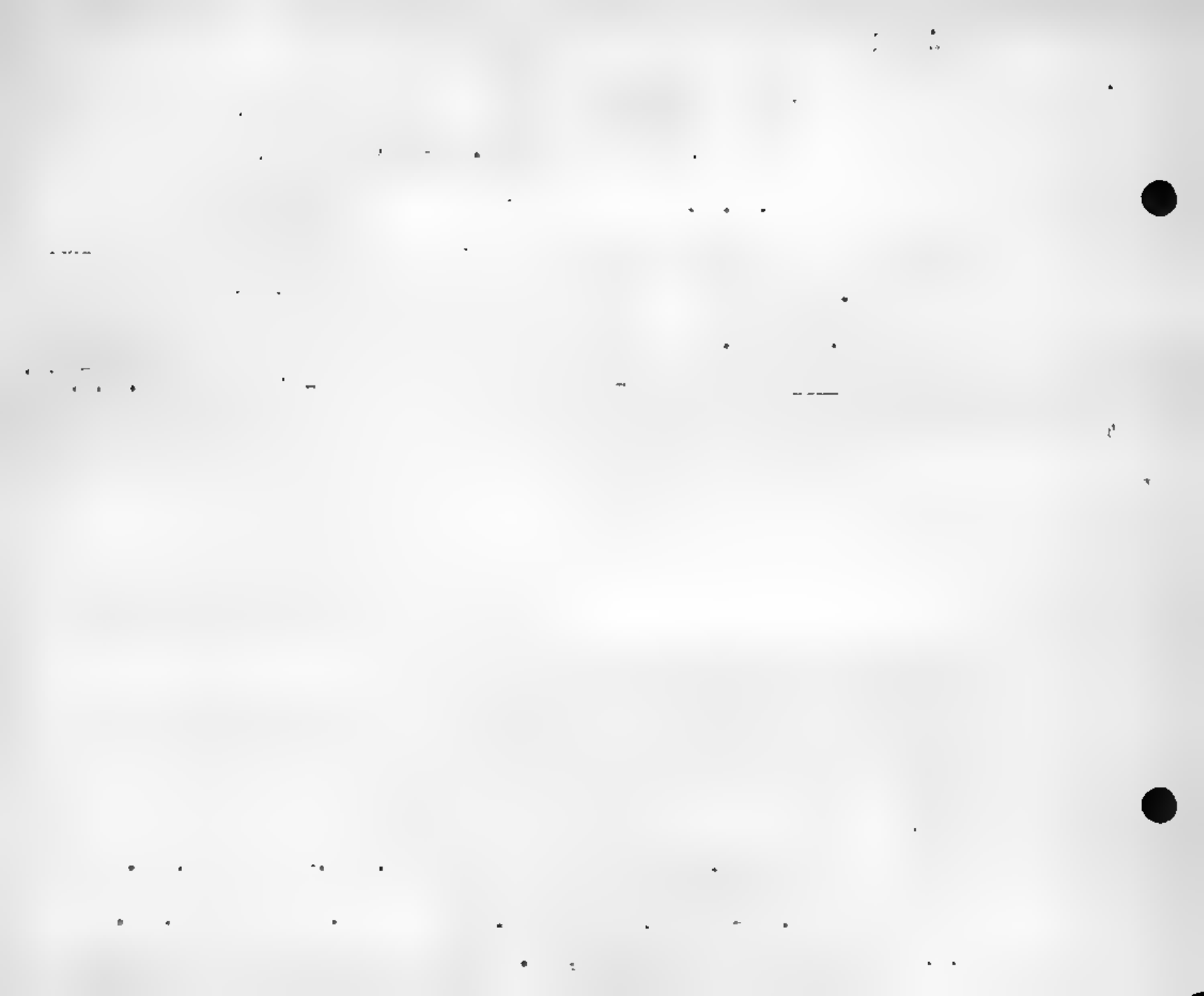
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expired within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-68  
304A REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
DECEASED NAME (Type or print)			First <b>Mary</b>			Middle <b>Catherine</b>			Last <b>Dodge</b>			2a. DATE OF DEATH Month <i>August</i> Day <i>14</i> Year <i>1968</i> 2b. HOUR <i>7:30</i> AM		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Jan. 26-1874</b>			6 AGE (In years last birthday) <b>94</b> VRS			7 UNDECEASED YEAR MONTHS <b>1</b> DAYS <b>14</b> HOURS <b>7</b> MIN <b>30</b>				
7a BIRTHPLACE (State or foreign country) <b>Ohio</b>			7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Montgomery</b> Md					
10 CITY OR TOWN OF DEATH <b>Kensington</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Hall Sanitarium</b>			12a USUAL OCCUPATION Kind of work done during most of working life, even if retired) <b>Homemaker</b>			12b KIND OF BUSINESS OR INDUSTRY					
3a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			3b COUNTY <b>Frederick</b>			3c CITY OR TOWN <b>Braddock</b>			3d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER		
14 FATHER'S NAME First <b>W.</b> Middle <b>W.</b> Last <b>Hoopes</b>			5 MOTHER'S MAIDEN NAME First <b>Virginia</b> Middle <b>Purdue</b> Last <b>Purdue</b>											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b SOCIAL SECURITY NO <b>579-48-3567D</b>			17 INFORMANT Address <b>Miss Beatrice Dodge-2733 Ordway St.-N.W. Wash.-D.C.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for a, (b) and c.)														
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) <u>Arteriosclerotic heart disease</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If neither, partly medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 3 or Part 2 Item 18.)								
22a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			22f. LOCATION Street or RFD No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 26 1968</u> to <u>Aug. 14 1968</u> , that (I) (we) lost the deceased alive on <u>Aug. 13 1968</u> , and that in (my) (our) opinion an death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE <u>Katharine A. Chapman, M.D.</u> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>August 14, 1968</u>					
22d. PHYSICIAN'S NAME (Type) <b>Katharine A. Chapman</b>						22e. ADDRESS <b>3924 Balto. Ave.-Kensington, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Aug. 16-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Frederick Mem. Park</b>			23d. LOCATION (City or Town) (County) (State) <b>W. of Frederick, Md.</b>					
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son</b>						ADDRESS <b>Frederick, Md. 21701</b>			25a. REC'D BY REGISTRAR DATE <b>AUG 19 1968</b>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The now requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

11702

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

710

1. DECEASED NAME (Type or print) First <b>Lottie</b> Middle <b>SWITZER</b> Last <b>Eberly</b>		2a. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1968</b>		2b. HOUR a.m. or p.m. <b>2:20 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>11/29/83</b>		6. AGE in years (last birthday) <b>84</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery County</b>
10. CITY OR TOWN OF DEATH <b>Takoma Park, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (Not in hospital give street address) <b>Washington San.</b>		12a. USUAL OCCUPATION Kind of work done during most of working life even if retired <b>Housewife</b>
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <b>D.C.</b>		13b. COUNTY	13c. CITY OR TOWN	13d. HOME CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>Benjamin</b> Middle <b>Switzer</b> Last <b>Eberly</b>		15. MOTHER'S M.A.D.E.N. NAME First <b>Rebecca</b> Middle <b>Fitz</b> Last <b>Eberly</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT <b>Mrs. Ruth Walker</b> Address <b>6939 Maple St. N.W. DC</b>
8. CAUSE OF DEATH Enter only one cause per line for a), b), and c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio-sclerotic Heart Disease</b>				<b>15 years</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Agranulocytic Anemia</b>				<b>2 years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Generalized Arteriosclerosis - 15 years</b>				
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/24/68</b> 19 to <b>8/30/68</b> 19, that (I) (we) (last saw the deceased alive on <b>8/30/68</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Francis X. Richardson</b>		22c. DATE SIGNED <b>8/31/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Francis X. Richardson, M.D.</b>
23a. B.R.A. CREMATION, REMOVAL (Specify)		23b. DATE <b>Sept-1-1968</b>		23c. NAME OF TEMP. OR CREMATORY <b>St. Paul's Lutheran Cemetery</b>
24. FUNERAL DIRECTOR <b>Arthur Walters</b>		25a. REC'D BY REGISTRAR <b>SEP 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

11704

11711

1 DECEASED NAME (Type or print) <i>Margaret HANNA Elder</i>			2a DATE OF DEATH Month <i>8</i> Day <i>4</i> Year <i>68</i>			2b HOUR M					
3 SEX <i>Female</i>		4 RACE <i>Cauc.</i>		5 DATE OF BIRTH <i>10-22-1888</i>		6 AGE (In years last birthday) <i>79</i> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE State or foreign country <i>Columbus, Ohio</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>			Md		
10 CITY OR TOWN OF DEATH <i>Washington, Md.</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Traviswood Nursing Home</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>social worker</i>		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased had admission) STATE <i>D. C.</i>		13b COUNTY <i>Washington</i>		13c CITY OR TOWN <i>Wash.</i>		13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>4222 Brandywine St. NW</i>			
4 FATHER'S NAME First Middle Last <i>John Calvin Hanna</i>				15 MOTHER'S MAIDEN NAME First Middle Last <i>Kittie Parsons</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO. <i>389-28-4599-11</i>		17 INFORMANT <i>Robert A. Elder-son</i>				Address <i>Same as #13</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4127</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Q.S.N.D.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis Cordis Vascular</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
9a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (either notify medical examiner)		2b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		2c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18.)							
2d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		2e PLACE OF INJURY (AT HOME - ARM - STREET - FACTORY) OFFICE BUILDING, ETC.		2f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from <i>6-1</i> 1968 to <i>8-4</i> 1968 that (I) (we) last saw the deceased alive on <i>8-3</i> 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did, did not) view the body after death											
22b SIGNATURE <i>Myron L. Lorton</i>				DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22d PHYSICIAN'S NAME (Type)				22e ADDRESS							
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE <i>8-5-1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>				23d LOCATION City or Town, County, State <i>Washington, D.C.</i>			
24 FUNERAL DIRECTOR <i>Lee Funeral Home-300 4th St. NE, Wash. DC</i>				25a REC'D BY REGISTRAR DATE <i>AUG 7 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATION

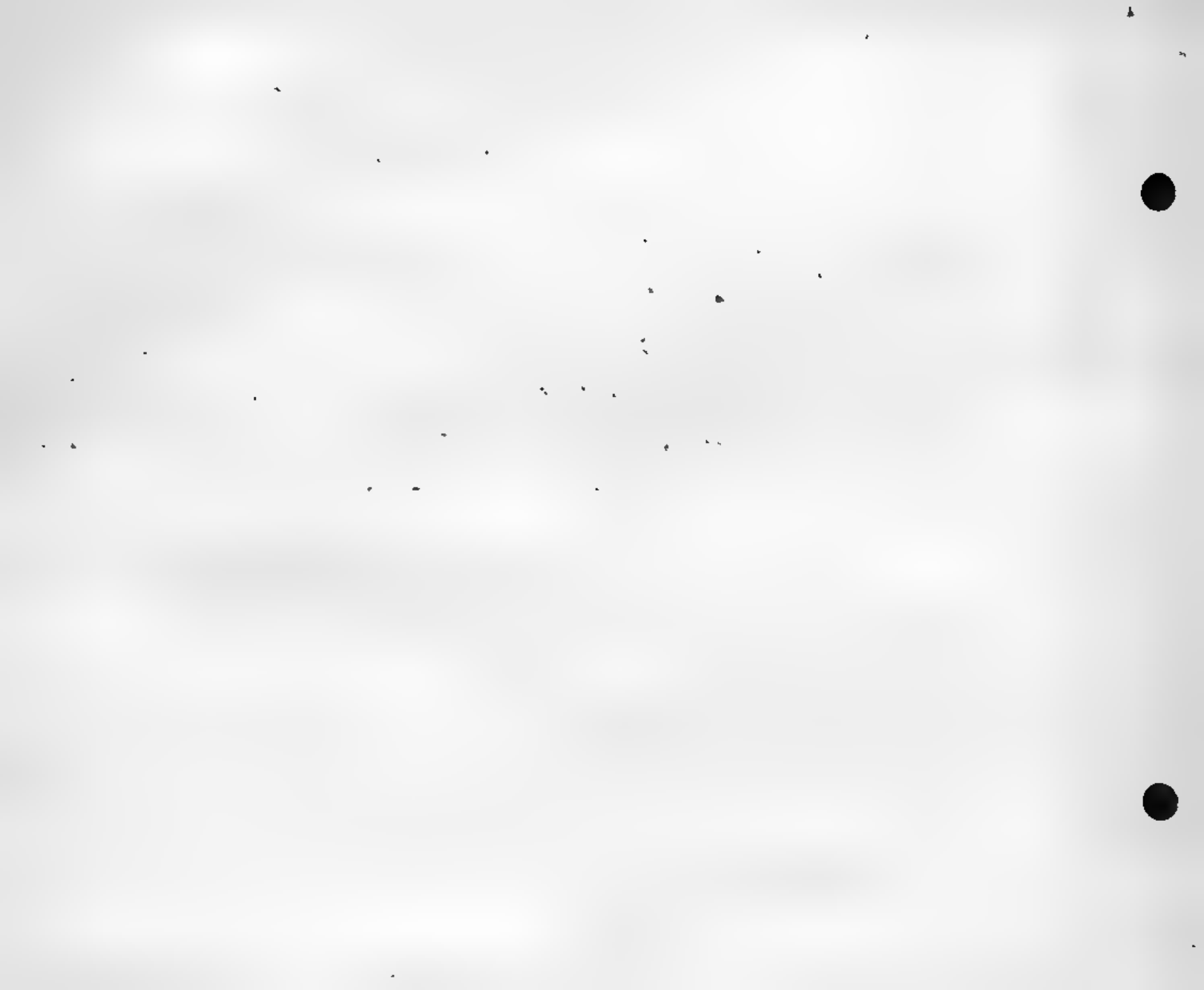
X



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11705		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				1171	
1 DECEASED NAME (Type or print)						2a DATE OF DEATH	
First <i>Viola</i> Middle <i>A. Engelbrecht</i> Last <i>Aug. 25, 1968</i>						Month Day Year	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE in years	
<i>Female</i>		<i>White</i>		<i>7/23/1895</i>		<i>73</i> YRS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
<i>Pennsylvania</i>		<i>USA</i>		<i>Montgomery</i>		<i>Mo</i>	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
<i>Bohemia</i>		<i>Suburban Housewife</i>		<i>Housewife</i>			
13a USAL RESIDENCE (Where deceased lived admission) STATE		13b INSTITUTION RESIDENCE BEFORE 13a		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<i>Dist of Columbia</i>		<i>Washington</i>		<i>3348</i>		<i>Military Rd</i>	
14 FATHER'S NAME First Middle Last		15 MOTHER'S M.A.DEN NAME First Middle Last		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give branch of service)		17 NEPOPHANT Address	
<i>John</i>		<i>Wray</i>		<i>Charles Engelbrecht Sr</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction, Acute</i>						<i>36 hrs</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Arteriosclerosis</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>410.7</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
<i>Carcinoma of Sigmoid Colon</i>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>Aug 23 68</i>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
<i>Not while at work</i>		<i>19</i>					
22a I certify that (I) (this hospital) attended the deceased from <i>8/21</i> , 19 <i>68</i> to <i>8/25</i> , 19 <i>68</i> that (I) (we) saw the deceased alive on <i>8/25</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death		22b SIGNATURE <i>William Lockett MD</i>		22c DATE SIGNED <i>8/25/68</i>			
22d PHYSICIAN'S NAME (Type) <i>WILLIAM LOCKETT</i>		22e ADDRESS <i>5000 RENO RD. NW, WASH, DC</i>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
<i>Removal</i>		<i>8-23-1968</i>		<i>Mount Olivet</i>		<i>Frederick, Maryland</i>	
24 FUNERAL DIRECTOR <i>Joseph Gwiler's Sons, Inc., 5130 Miso. Ave. N.W., Wash., D.C.</i>				25a RECD BY REGISTRAR DATE <i>AUG 30 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11706

11713

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print) <span style="float:right">First Middle Last</span> May <span style="float:right">M. <del>1968</del> Evans</span>			2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <span style="float:right">2b HOUR 6:52</span>	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 11/2/1890	6 AGE In years (last birthday) 77 <del>78</del> YRS	7c DATE PRONOUNCED DEAD Month 8 Day 9 Year 1968 <span style="float:right">2d HOUR 7:52</span>
7a BIRTHPLACE (State or foreign country) Washington DC		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross		9 COUNTY OF DEATH Montgomery
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross		2a USUAL OCCUPATION (Kind of work done during most of working life, or when if retired) Late Ins Work
13a USUAL RESIDENCE (Where deceased lived, if not in hospital residence be on admission) STATE MARYLAND		3b COUNTY Montgomery		2b KIND OF BUSINESS OR INDUSTRY Life Ins Co
13c STREET AND NUMBER 12827 Valleywood Dr.				
14 FATHER'S NAME First Middle Last William Edward Evans		15 MOTHER'S MAIDEN NAME First Middle Last Annie <del>Mc</del> Bou		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) NO		16b SOCIAL SECURITY NO 577-10-0525		17 INFORMANT ADDRESS J E McCormick 2806 Henderson Ct. Cheverton, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>				
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>01</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug. 9, 1968</u>		
EXAMINER'S NAME Type BELDEN R. KEAP M.D.		22b. DATE SIGNED		
23a. BURIAL (Cremation, Removal, Specimen)		23b. DATE August 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
23d. LOCATION (City or town) Switland		23e. COUNTY Prince George's		23f. STATE Maryland
24. FUNERAL DIRECTOR M. Andrew Duwall		25a. REC'D BY REG. STRAR AUG 14 1968		25b. REG. STRAR'S SIGNATURE <u>James S. Humphrey</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

11707		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				714	
1 DECEASED-NAME (Type or print) First Middle Last Emeline Frey Falck			2a DATE OF DEATH Month Day Year 8 23 68			2b HOUR 4 A.M.	
3 SEX Fem.		4 RACE White		5 DATE OF BIRTH 9/5/35		6 AGE (in years last birthday) 32 YRS	
7a BIRTHPLACE (State or foreign country) New York		7b CITIZEN OF WHAT COUNTRY? Amer.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wash. San + Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) None		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission, STATE Md		13b COUNTY Montgomery		13c CITY OR TOWN Washington		13d INSIDE CITY WARD? Dis No	
14 FATHER'S NAME First Middle Last Hans Frey		15 MOTHER'S MAIDEN NAME First Middle Last Rosalie		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no or unknown No			
16b SOCIAL SECURITY NO 579-60-1924		17 INFORMANT Patient's chart				Address	
B CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days
DUE TO OR AS A CONSEQUENCE OF (b) Kidney failure, dehydration, Hb Bessing							
DUE TO OR AS A CONSEQUENCE OF (c) Antineoplastic Chemotherapy							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Hb Bessing Cause Unknown							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b,			
22a INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		22a PLACE OF INJURY (AT HOME - ARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		22b LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from Aug 1966 to Aug 23, 1968 that (I) (we) last saw the deceased alive on Aug 22, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death							
22b SIGNATURE Russell C. B. B. M.D.		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED Aug 23, 68	
22d PHYSICIAN'S NAME (Type) Russell C. B. B. M.D.		22e ADDRESS 1429 Univ. Blvd W S.W. Washington					
23a RULING CREMATION, REMOVAL (Specify) cremation		23b DATE 8/24/68		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory Prince Georges County		23d LOCATION (City or Town) (County) (State)	
24 FUNERAL DIRECTOR THE S.H. HINES CO		ADDRESS 2901-14TH ST. N.W. WASH. D.C.		25a REC'D AUG 27 1968		25b REGISTRAR'S SIGNATURE Johnas Judge	



VR A 5/14/75  
30M REV 65



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR-A15 (4)  
30MA REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
CLAYTON			IT		FASSANELLA	Aug 2 68		11:50 AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years) most birthday, YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE		white		SEPT 7 1909		58			
7a BIRTH PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
New York		U.S.A				Montgomery Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA			Suburban			Retired			
17a. U.S.A. RESIDENCE (Where deceased lived if institution: Residence before admission) STATE			13b. COUNTY		14 INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Montgomery				1311 PARKLAND DRIVE		
14 FATHER'S NAME			Middle		Last		5 MOTHER'S M.A.D.E.N. NAME First Last		
Joseph			Fassarella		Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If not, give year of service)			16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
Yes			128-07-4201		Wife FASSANELLA		1311 Parkland Dr Bethesda, Md		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Lung								4 years.	
1621 DUE TO, OR AS A CONSEQUENCE OF									
Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
9a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 17, 1968 to August 2, 1968, that (I) (we) last saw the deceased alive on August 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		22e. DATE SIGNED	
J. Blaine Fitzgerald			J. Blaine Fitzgerald			8218 Wisconsin Avenue Bethesda		8-3-68	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
			8/6/68		Balt. Nat + Cem		Baltimore Md		
24 FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
W.N. Chambers, Inc			8655 G2 AVE Silver Spring Md			AUG 8 1968 J. Charles Jorgensen			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial or cremation, or removal, and in any event with a 72 hours after death.

11716

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11717

CERTIFICATE OF DEATH

DECEASED NAME (Type or print) First Middle Last <b>Herman Edward FISCHER</b>			2a. DATE OF DEATH Month Day Year <b>August 11 1968</b>		2b. HOUR <b>6:05A</b>
1. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>August 10, 1890</b>		6. AGE (In years last birthday) <b>78</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		2a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>USN</b>		2b. KIND OF BUSINESS OR INDUSTRY
3a. USUAL RESIDENCE (Where deceased lived if institution: Residence before death) City, State, Zip <b>Washington D.C.</b>	3b. CITY OR TOWN <b>Washington D.C.</b>	3c. CITY OR TOWN <b>Wash. D.C.</b>	13a. INSIDE CITY (MAY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>3015 14th St. N.W.</b>	
4. FATHER'S NAME First Middle Last <b>Ferdinand C. FISCHER</b>		5. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <b>1942-46</b>		6b. SOCIAL SECURITY NO <b>579-50-5302</b>	7. INFORMANT (Daughter)		Address <b>Wash. D.C.</b>
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (Either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 9		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, ARMED SERVICES, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 18 1968</b> to <b>August 11 1968</b> that (we) last saw the deceased alive on <b>August 11 1968</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did not) view the body after death.					
22b. SIGNATURE <i>R. D. Gaskins</i>		22c. DATE SIGNED <b>12 Aug 68</b>		22d. PHYSICIAN'S NAME (Type) <b>R. D. GASKINS</b>	
22e. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>		23a. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery, Arlington, Virginia</b>			
23b. DATE <b>8-13-1968</b>		23c. LOCATION City or Town (County) State <b>Arlington, Virginia</b>		23d. RECORD BY REGISTRAR <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Gawler's Funeral Home, 5130 Wisc. Ave., WDC</b>		24a. RECD BY REGISTRAR <b>AUG 13 1968</b>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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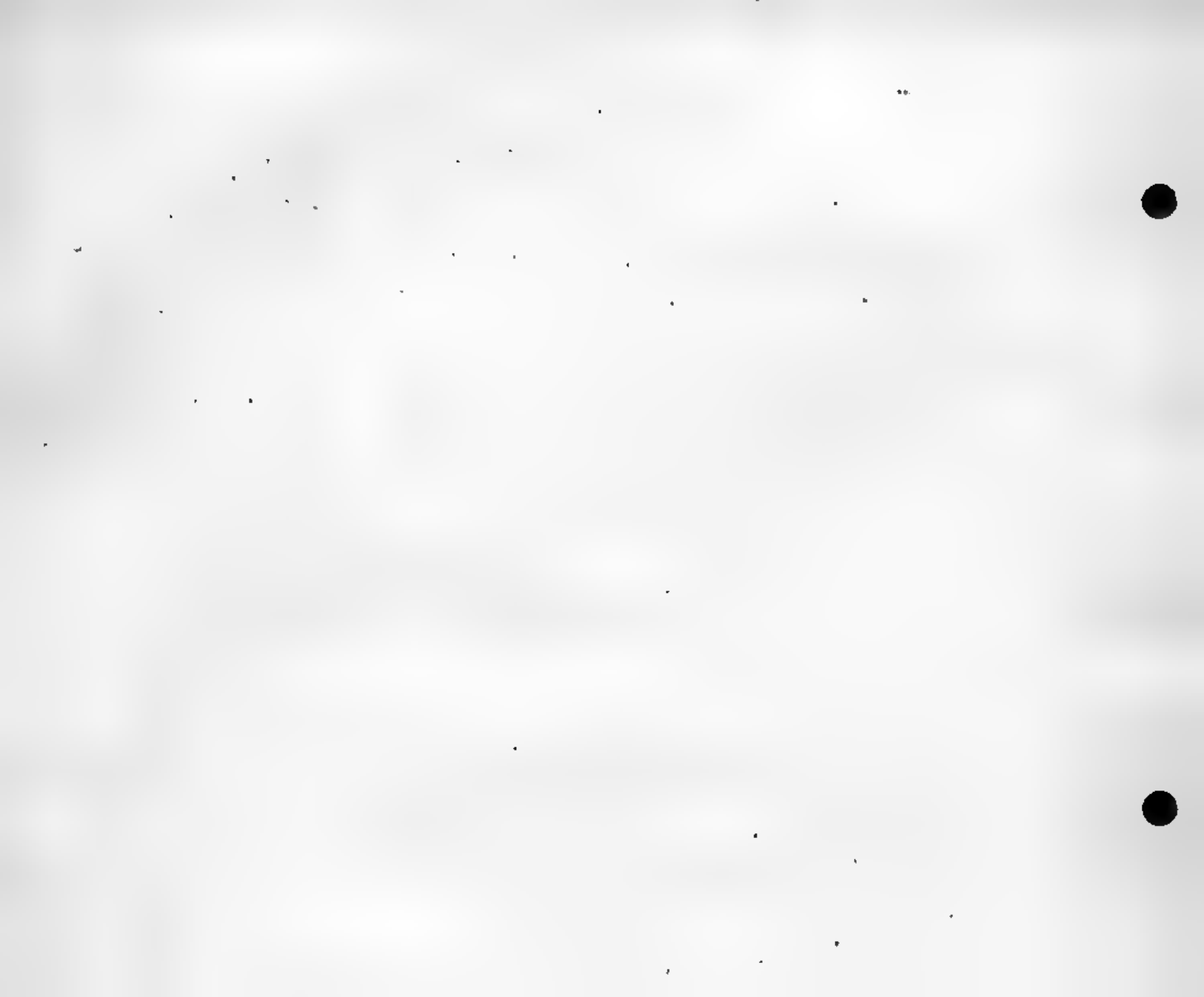
11711

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

718

1 DECEASED NAME (Type or print) <b>JOHN Aloysious FLAHERTY</b>			2a DATE OF DEATH August 15 Day 68 Year		2b HOUR 4:45 P.M.
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>June 21, 1886</b>	6 AGE in years last birthday, <b>82</b> YRS.	IF UNDER YEAR MONTHS DAYS	11 UNDER 24 MRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH (82) <b>Montgomery</b>		
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>	11 NAME OF HOSPITAL OR INSTITUTION (Not in hospital give street address) <b>WASHINGTON SANITARY Hosp. Dricklayer</b>	12a U.S.A. OCCUPATION (If not at work done during last 7 days, even if retired)	2b KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a JAL. RESIDENCE (Where deceased lived if institution Residence before admission) STATE <b>MARYLAND</b>	13b COUNTY <b>MONTGOMERY</b>	13c CITY OR TOWN <b>Silver Spring</b>	3a INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	3b STREET AND NUMBER <b>#10500 New Hampshire</b>	
14 FATHER'S NAME First Middle Last <b>Edward Flaherty</b>	15 MOTHER'S MAIDEN NAME First Middle Last <b>Minnie Gleason</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)	16b SOCIAL SECURITY NO. <b>Unknown</b>	17 INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bacterial Meningitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral Bacterial Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Pulmonary Emphysema - Atherosclerotic Disease</b> CONDITIONS (if any) which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cardiovascular Disease</b>					
9a DATE OF OPERATION	9b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If neither, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (At home farm street factory) <input type="checkbox"/> OFFICE BUILDING ETC <input type="checkbox"/>	21f LOCATION Street or R.F.D. No	City or Town	County	State
22a I certify that (I) (the hospital) attended the deceased from <b>Mar 19 66</b> to <b>8 15 19 68</b> that (I) (we) last saw the deceased alive on <b>8 15 19 68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death					
22b SIGNATURE <b>Morton Altschuler M.D.</b>		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c DATE SIGNED <b>8-15-68</b>	
22d PHYSICIAN'S NAME (Type) <b>Morton Altschuler M.D.</b>		22e ADDRESS <b>9205 New Hampshire St.</b>			
23a BURIAL, CREMATION, REMOVAL, ETC. <b>BURIAL</b>	23b DATE <b>8-19-68</b>	23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>		
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> ADDRESS <b>4308 Suitland Rd. Suitland, Maryland</b>			25a REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>	
			DATE <b>AUG 27 1968</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
11712						11719					
1 DECEASED NAME (Type or print) <sup>First</sup> Jesse <sup>Middle</sup> B. <sup>Last</sup> Floyd						2a DATE OF DEATH <sup>Month</sup> Aug. <sup>Day</sup> 1 <sup>Year</sup> 1968			2b HOUR 3:25 AM		
3 SEX Male		4 RACE White		5 DATE OF BIRTH June 2, 1894		6 AGE in years last birthday 74 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Tennessee		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.					
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY Fed. Govt		
13a U.S. RESIDENCE (Where deceased lived, if instt from Residence before admission) STATE Md.			13b COUNTY Montgomery			13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 112 N Van Buren.	
14 FATHER'S NAME <sup>First</sup> James F. <sup>Middle</sup> Floyd <sup>Last</sup>						15 MOTHER'S MAIDEN NAME <sup>First</sup> Maggie <sup>Middle</sup> Oslin <sup>Last</sup>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or UNKNOWN Yes WWI				16b SOCIAL SECURITY NO 214-16-8937		17 INFORMANT Gretchen L. Floyd - wife - same item # 13 Address					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Anteroseptal Heart Disease (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 15 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Pulmonary Emphysema											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)							
22a INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		22b PLACE OF INJURY (A HOME ARM. STREET FACTORY) OFFICE BUILDING ETC		22c LOCATION Street or R.F.D. No. City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from August 1960 to 8/1/1968 that (I) (we) last saw the deceased alive on 7/31/1968, and that (my) (our) opinion on death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b SIGNATURE Robert C. Macon DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c DATE SIGNED					
22d PHYSICIAN'S NAME (Type) Robert C. Macon						22e ADDRESS 809 Viero Mill Rd. Rockville, Md.					
23a BURIAL, CREMATION, REMAINS (Specify)		23b DATE 8/3/68		23c NAME OF CEMETERY OR CREMATORY Allen Cemetery		23d LOCATION (City or Town) (County) (State) Caney Spring, Tennessee					
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home				25a REC'D BY REGISTRAR AUG 5 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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11712

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

11720

1 DECEASED NAME (Type or print) <b>MOLLIE</b>			First Middle Last <b>FOOTER</b>			2a DATE OF DEATH Month Day Year <b>8 6 68</b>			2b HOUR <b>12:10</b>		
3 SEX <b>Female</b>			4 RACE <b>Caucasian</b>			5 DATE OF BIRTH <b>5/15/1870</b>			6 AGE (In years last birthday) <b>98</b> YRS		
7a BIRTHPLACE (State or foreign country) <b>Russia</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Montgomery</b> Md		
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chevy Chase Nurs. Home</b>			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
3a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Wash., D.C.</b>			3b COUNTY <b>D.C.</b>			3c CITY OR TOWN <b>Wash, D.C.</b>			3d RESIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Middle Last <b>Yaakove Winogradsky</b>			5 MOTHER'S MAIDEN NAME First Middle Last <b>Zlota Yogubsky</b>			13a STREET AND NUMBER <b>400 Farragot St. N.W.</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>			16b SOCIAL SECURITY NO.			17 INFORMANT <b>Irvin Footer</b>			Address <b>7667 Maple Ave. Takoma Park, Md</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 month</b> <b>10 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)											
9a DATE OF OPERATION			9b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (either, natly, medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>9</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
2a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19 <b>8/6</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/4</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d) (did not) view the body after death											
22b SIGNATURE <b>Morris H Rosenberg MD</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED <b>8/6/68</b>		
22d PHYSICIAN'S NAME (Type) <b>MORRIS H ROSENBERG MD</b>						22e ADDRESS <b>2141 W ST NW</b>					
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>8/8/68</b>			23c NAME OF CEMETERY OR CREMATORY <b>Agudath Achim Cem.</b>			23d LOCATION (City or Town) (County) (State) <b>Hyattsville, Md.</b>		
24 FUNERAL DIRECTOR <b>Bernard Danzansky &amp; Sons</b>						ADDRESS <b>3501 14th St NW Wash., D.C. 20004</b>			25a REC'D BY REGISTRAR <b>AUG 12 1968</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)  
304A REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																										
CERTIFICATE OF DEATH																										
1 DECEASED NAME (Type or print)			First Louis			Middle (None)			Last Freedman			2a DATE OF DEATH Month August			Day 15			Year 1968			2b HOUR A 7:20			M		
3 SEX Male			4 RACE White			5 DATE OF BIRTH 25 September 1906			6 AGE (in years last birthday) 61			7 UNDER YEAR MONTHS YRS			8 UNDER YEAR MONTHS DAYS			9 UNDER 24 HRS HOURS MIN								
7a BIRTHPLACE (State or foreign country) New York			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery						Md.											
10 CITY OR TOWN OF DEATH Bethesda			1 NAME OF HOSPITAL OR INSTITUTION The Clinical Center, NIH			12a USUAL OCCUPATION Kind of work done during past 12 months (even if retired) Salesman			2b KIND OF BUSINESS OR INDUSTRY Shoe																	
3a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Arizona			3b COUNTY Tucson			3c CITY OR TOWN Tucson			3d HOME CITY (H-15) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3e STREET AND NUMBER 4453 East Lee Street														
14 FATHER'S NAME Bernard			First Freedman			5 MOTHER'S MAIDEN NAME Rebecca			First Sussman																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)			16b SOCIAL SECURITY NO. 096-07-4233			17 INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland																				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia with Septicemia 2/5/1 DUE TO, OR AS A CONSEQUENCE OF (b) Hypogammaglobulinemia with Thymoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 8 years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 092 Metastatic Liposarcoma																										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes																	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State																				
22a I certify that (X) (this hospital) attended the deceased from 16 May, 1968 to 15 Aug., 1968, that (X) (we) last saw the deceased alive on 15 August, 1968 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (d) (d) (did not) view the body after death																										
22b SIGNATURE R. Peter Mogielnicki												DEGREE ATTENDING PHYS.			MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c DATE SIGNED 15 August 1968								
22d PHYSICIAN'S NAME (Type) R. Peter Mogielnicki, M.D.												22e ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland														
23a BIRTHPLACE (State or foreign country) New York			23b DATE 8/17/68			23c NAME OF CEMETERY OR CREMATORY Catharine Cemetery			23d LOCATION (City or Town) Vineland, New York			(County) (State)														
24 FUNERAL DIRECTOR W.W. Charles Co 1400 Ave. St. Louis Ave.												25a REC'D BY REGISTRAR DATE AUG 19 1968			25b REGISTRAR'S SIGNATURE Charles Judge											

MEDICAL CERTIFICATE ON



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word pending in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR-Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
11715			Items 9 & 10 of Form 10-404 9/16/68 kk 722							
DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b MONTH DAY YEAR		
MICHAEL JOHN FRIEDL							8-12		1968	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PROMULGED DEAD		2d MONTH DAY YEAR		
MALE	WHITE	2-6-93	75 YRS	MONTHS DAYS	HOURS MIN	Month 8 Day 22 Year 1968		1968		
7a BIRTHPLACE State or foreign country		7b COUNTRY OF BIRTH		8 MARRIED		9 COUNTY OF DEATH		2e DATE OF DEATH		
ROMANIA		STATELESS		NEVER MARRIED		MONTGOMERY		10-20		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (Give street address)			12a USUAL OCCUPATION		12b KIND OF BUSINESS OR INDUSTRY		
FULTON, Cincy			DOA MONTGOMERY GENERAL			RETIRED		CARPENTER		
13a US RESIDENCE Where deceased lived 1 in institution 2 in private residence before death			3c CITY OR TOWN			13b STREET AND NUMBER		13c ADDRESS		
VIRGINIA			WOODBIDGE			101 GERMYN RD.				
4 FATHER'S NAME			5 MOTHER'S MAIDEN NAME			6 ADDRESS		7 ADDRESS		
MICHAEL JOHN FRIEDL			MARGARITA HEINRICH			FULTON, MD.				
16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO.			17 INFORMANT		18 ADDRESS		
NO			097-03-1914			CHRISTINA CARR		FULTON, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>										
(b) <u>Arteriosclerotic Heart Disease</u>										
(c) <u></u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										
20. AUTOPSY?										
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED				
			Month Day Year			(Enter nature of injury in Part 1 or Part 2, item 8.)				
22a. INJURY OF			22b. PLACE OF INJURY			22c. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			At home, farm, street, factory, office building, etc.)			Street or RFD No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			22c. DATE SIGNED				
Belden R. Read, M.D.			DEPUTY MEDICAL EXAMINER			Aug. 22, 1968				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR REMATORY			23d. LOCATION	
Burial			26 Aug 68			Mount Comfort Cemetery			Fairfax Co., Virginia	
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Cunningham-Mountcastle Funeral Home			AUG 27 1968			Charles Judge				

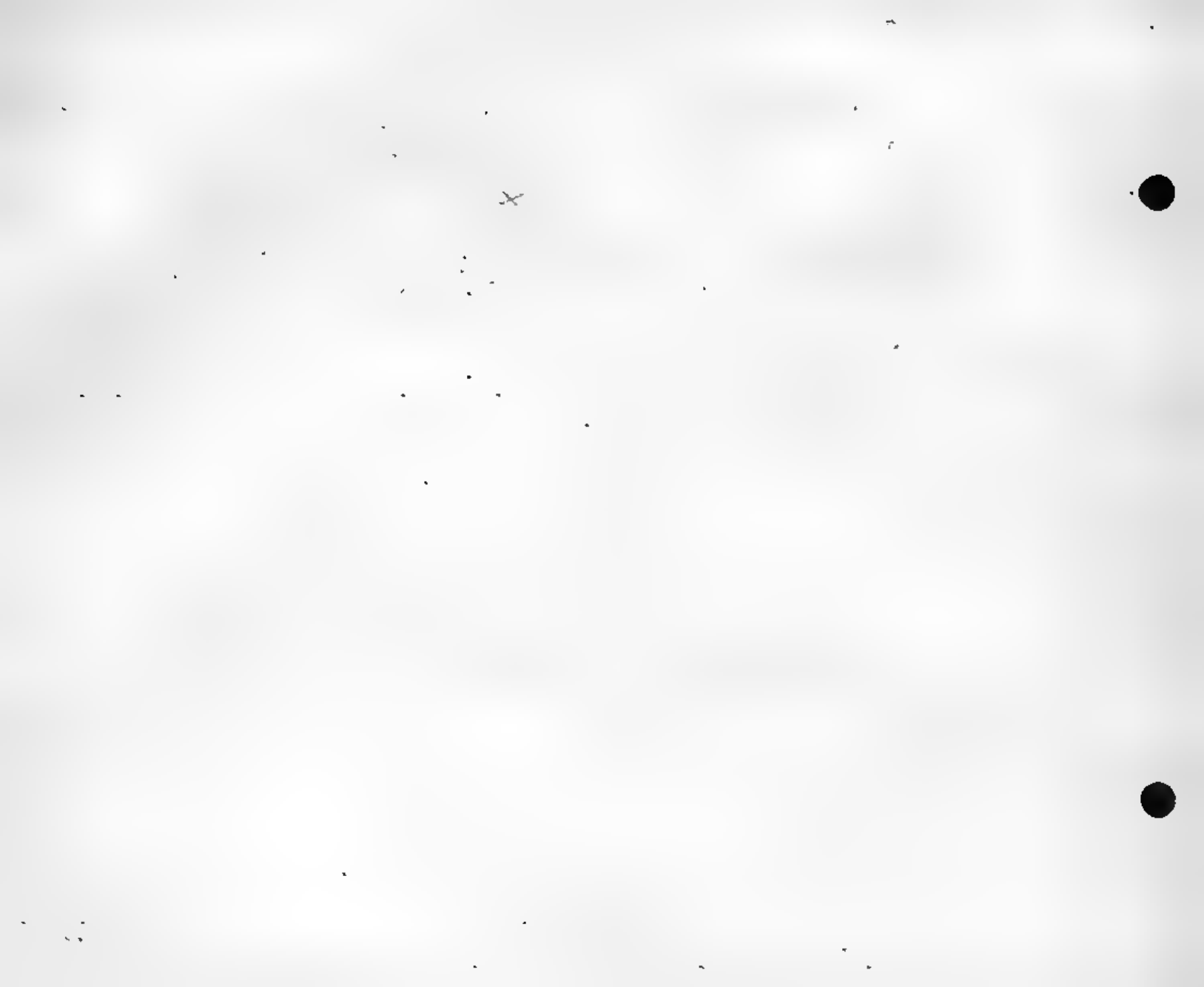


TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with not more than 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR 415  
30M REV 108

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			2a. DATE OF DEATH			2b. HOUR			
First Middle Last Guadalupe R. GARCIA			8 Month 6 Day 68 Year			12:45 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years)		7. UNDER 1 YEAR	
Female		White		12-12-1903		71 YRS		MONTHS DAYS HOUR MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MEXICO		U.S.A.				MONTGOMERY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. U.S.A. OCCUPATION (kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross Hosp.			housewife		own home	
13a. U.S.A. RESIDENCE (where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c. STREET AND NUMBER		13d. INSIDE CITY LIMITS	
MD.			Montgomery			12700 Bushy Drive		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4. FATHER'S NAME			5. MOTHER'S M.A.D.E.N NAME						
First Middle Last Camilo - - Rios			First Middle Last Adele - - - Prado						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			
Yes, NO or unknown			No			Mrs. Emma G. Maier 12,700 Bushy Dr. S.S. Md.			
8. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Stroke &amp; Pyelonephritis (peritonitis)</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>Age</u>									<u>6 days</u>  <u>Years</u>  <u>Years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2 Item 18.)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No City or Town County State			
22a. I certify that (i) (this hospital) attended the deceased from August 19 65 to August 19 68 that (I) (we) last saw the deceased alive on August 5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
Hugo G. Graziani						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		8/6/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
HUGO G. GRAZIANI, MD.						10101 Georgia Ave., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town, County)		23e. (State)	
Burial		August 9, 1968		Gate of Heaven Cemetery		Silver Spring, Mont.		Md.	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Warner E. Humphrey, Inc. 8434 Co. Ave. S.S.						DATE AUG 9 1968		John J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11717

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

11724

1 DECEASED NAME Type or print First Middle Last George L. Gardaya			2a DATE OF DEATH Month Day Year August 19 1968			2b HOUR 11:30 AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH July 22 1902		6 AGE (In years last birthday) 66 YRS	
7a BIRTHPLACE State or foreign country Hill, Va		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Belmont Park		NAME OF HOSPITAL OR INSTITUTION (not in hospital give street address) Wash. Gen. Hosp		12a USA, OCCUPATION Kind of work done during most of working life even (retired) Army Major		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) STATE DC		13b COUNTY Washington		13c STREET AND NUMBER 829 Whittier Pl NW			
4 FATHER'S NAME First Middle Last Unknown				5 MOTHER'S MAIDEN NAME First Middle Last UNKNOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO UNKNOWN		17 INFORMANT ROSE B GARDAYA (WIFE)		Address 829 WHITTIER PL NW WASH DC	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4107 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arterio-sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) T 121							
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		2 HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
2d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from Aug 16, 1968 to Aug 19, 1968 that (I) (we) last saw the deceased alive on Aug 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death							
22b SIGNATURE A. B. Little M.D.		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED Aug. 19, 1968	
22d PHYSICIAN'S NAME (Type) A. B. LITTLE M.D.		22e ADDRESS 6411 5th St NW Wash DC 20012					
23a B.R.A. CEMETERY OR CREMATORY BURNING		23b DATE 8-22-68		23c NAME OF CEMETERY OR CREMATORY F LINCOLN CEM		23d LOCATION (City or Town) County State BLADENSBURG MD	
24 FUNERAL DIRECTOR W.W. Chapman - Reed Chapman		ADDRESS		25a REC'D BY REGISTRAR AUG 22 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Copy Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal and in any event within 72 hours after death.

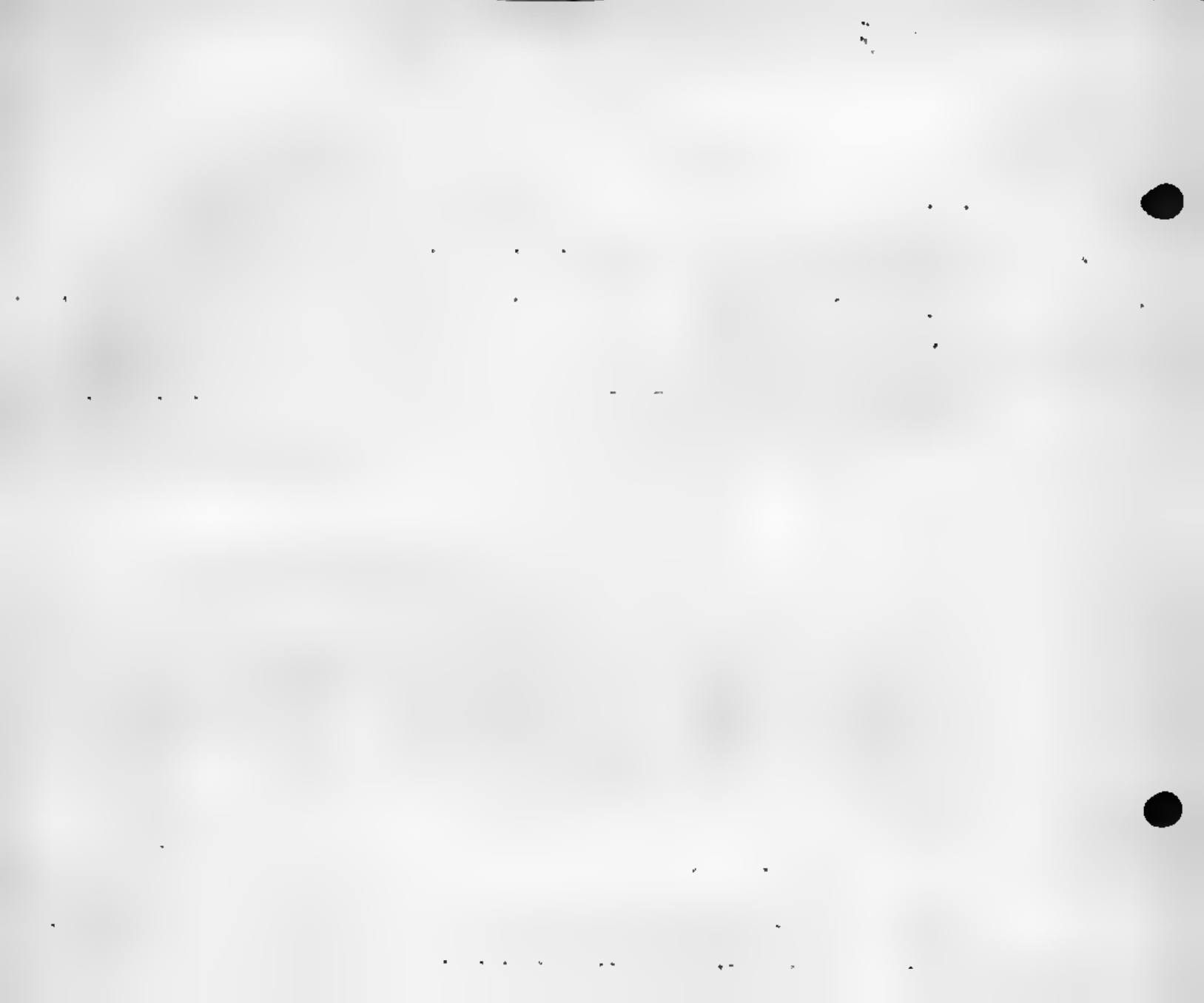
11718

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25

1 DECLARED NAME (Type or Print)		F. S. Middle Last		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year		2b HOUR	
ANNA MARIE GARRETSON				8-13-68		8:55 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	7 UNDER 24 HRS HOURS MIN	2. DATE PRONOUNCED DEAD Month Day Year	
Female	White	8-13-27	35 YRS			8 Day 13 Year 68 8:55 PM	
7a BIRTHPLACE State or foreign country		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
W.Va.		USA				Montgomery	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (Not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during last 12 months)		12b KIND OF BUSINESS OR INDUSTRY	
Takoma Park,		Wash. San. & Hosp.		Housewife born home			
3a USUAL RESIDENCE Where deceased lived 1 night or more on Residence before admission) STATE		3b COUNTY		3c CITY OR TOWN		3d INSIDE CITY IN Y.S. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		Montgomery		S.S.		1022 University Blvd., E.	
4. FATHER'S NAME First Middle Last		5. MOTHER'S MAIDEN NAME First Middle Last					
William Burnette		Sarah					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS	
None No		235-568-005		Jerry Tipton - Daughter		1022 Univ. Blvd. E. S.S. Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b). DUE TO OR AS A CONSEQUENCE OF (c).		Multiple Extreme Injuries with Exsanguination, incurred in auto accident.					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, per 181)			
		7-13-68		Deceased, passenger, injured when driver hit pole.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory office business etc)		21f. LOCATION Street or RFD No City or Town County State			
		Street		6300 Bk. New Hamp Ave, Tak. Pk. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		Belden R. Reap, MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		8-14-68	
23c. BURIAL (CREMATION REMOVAL) (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION City or Town County State	
Burial		Aug. 16, 1968		Parklawn Cemetery		Rockville Montg. Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTERED	
C/Glen Carter & Son, Inc., 8434 Ga., Ave. S.S. Md.				AUG 19 1968		J. J. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate, be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then place in envelope with carbon papers. Pages 1 and 2 should be filed with the State Dept of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11713

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1726

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) James Otto Gehrman			2a. DATE OF DEATH Month 8 Day 18 Year 68			2b. HOUR 7:20 PM				
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH 10/22/1901		6. AGE (In years last birthday) 66 YRS.		7. UNDER YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Buffalo, N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Wheaton			11. NAME OF HOSPITAL OR INST. TELL ON (not in hospital give street address) 901 ...			12a. US-A. OCCUPATION (Kind of work done during most of working life even if retired) Painter			12b. KIND OF BUSINESS OR INDUSTRY Painting	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Washington, DC			13b. COUNTY -			13c. CITY OR TOWN Washington			13d. STREET AND NUMBER 200 Elm St. S.	
4. FATHER'S NAME First Middle Last Carl Gehrman			5. MOTHER'S MAIDEN NAME First Middle Last Pauline - - Senara							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give date or dates of service) Yes 2			16b. SOCIAL SECURITY NO. 220-01-2525			7. INFORMANT Mrs. Bertha Miller 9 Hamason Ave. Buffalo N.Y.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE 10 1651 Carcinoma, Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause a stating the underlying cause last 163x PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIB. TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163x									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
19a. DATE OF OPERATION 6-68			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. LUNG			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR ON BICYCLE <input type="checkbox"/> OR IN DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) (OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (i) (this hospital) attended the deceased from JAN. 1968 to AUG 18, 1968 that (I) (we) last saw the deceased alive on AUG 18, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Leroy Robins						22c. DATE SIGNED 8-18-68				
22d. PHYSICIAN NAME Type LEROY ROBINS						22e. ADDRESS 2486-16th ST NW WOOD DC				
23a. BURIAL CREMATION Crematory			23b. DATE August 21, 1968			23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory			23d. LOCATION (City or Town) County (State) Prince George's Maryland	
24. FUNERAL DIRECTOR M. Andrew Luvall M. Andrew Luvall Warner E. Pumphrey Inc. 8434 Georgia Ave. SS.						25a. REC'D BY REGISTRAR DATE AUG 23 1968			25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The following requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transcript. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health promptly by the funeral director, and, in any event, within 72 hours after death.

Decided - 11/17/67

11720

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

11727

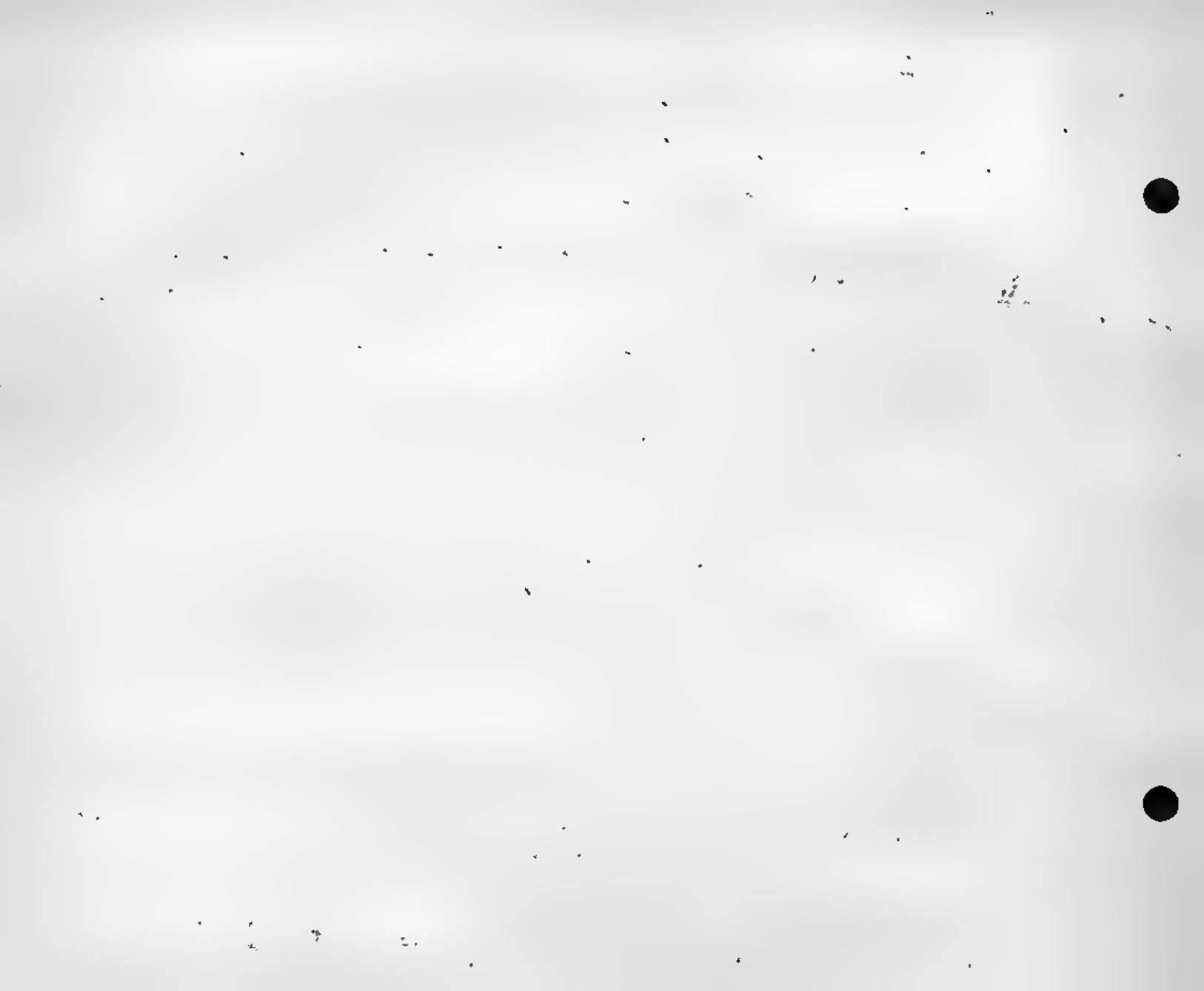
1 DECEASED NAME (Type or print) <b>Henry</b>		2a. DATE OF DEATH <b>Aug. 10 1968</b>		2b. HOUR <b>AM</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>June 21, 1909</b>	
7a BIRTH PLACE (State or foreign country) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6 AGE (In years last birthday) <b>59</b> YRS.	
7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>			
10 CITY OR TOWN OF DEATH <b>Wheaton</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Holy Cross</b>		2a. USUAL OCCUPATION (Kind of work done during most of last year (retired)) <b>Sergeant of guard</b>	
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE <b>Maryland</b>		3b. COUNTY <b>Montgomery</b>		2b. KIND OF BUSINESS OR INDUSTRY <b>USA</b>	
3c. CITY OR TOWN <b>Wheaton</b>		13b. INSIDE CITY - (HMS?) <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13c. STREET AND NUMBER <b>3711 Fairly St.</b>	
4 FATHER'S NAME <b>John</b>		5 MOTHER'S MAIDEN NAME <b>Mary</b>		6. BOUND	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>087-16-0618</b>		7. INFORMANT <b>Lillian Gengler 3711 Fairly St., Wheaton</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>Coronary Arterio-sclerosis Undetermined</b> DUE TO, OR AS A CONSEQUENCE OF <b>Diabetes Mellitus Undetermined</b>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Cerebral Arterio-sclerosis Amputation Right Leg</b>					
9a. DATE OF OPERATION <b>11/17/67</b>		19. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene foot</b>		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING FOR CONTRIBUTING TO DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>PM 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 29 1960</b> to <b>Aug 10 1968</b> that (I) (we) last saw the deceased alive on <b>June 28 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and, if desired, others) view the body after death					
22b. SIGNATURE <b>George L Ball</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>Aug 10, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>George L Ball</b>		22e. ADDRESS <b>6020 Georgia Ave Silver Spring Md</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>13 AUG. 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>	
23d. LOCATION (City or Town) (County) (State) <b>Silver Spring Md.</b>		24. FUNERAL DIRECTOR <b>RINARDI FUNERAL HOME, 7400 GEORGIA AVE, N.W.</b>			
25a. REC'D BY REGISTRAR <b>DATE AUG 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filed in by the funeral director. After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal and, in any event, within 72 hours after death.

VR A 5 (4)  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
11722												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) <i>Henrietta Mae Giarth</i>						2a DATE OF DEATH Month <i>Aug</i> Day <i>1</i> Year <i>1968</i>			2b HOUR <i>6:15</i> M			
3 SEX <i>female</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>2/27/97</i>		AGE in years at birthday <i>71</i> YRS		6 UNDER 1 YEAR MONTHS <i>11</i> DAYS <i>11</i>		7 UNDER 24 HRS HOURS <i>11</i> MIN <i>15</i>		
7c BIRTHPLACE (State or foreign country) <i>Pa.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md						
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban Hospital</i>				2a USUAL OCCUPATION (Kind of work done during most of working life) <i>Homemaker</i>			12b KIND OF BUSINESS OR INDUSTRY			
3a USUAL RESIDENCE Where deceased lived, if institution (Residence before admission) STATE <i>md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Rockville</i>		13a INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9e STREET AND NUMBER <i>1206 Broadwood Dr</i>				
4 FATHER'S NAME First <i>William C.</i> Middle <i>Featry</i> Last <i>Featry</i>				15 MOTHER'S MAIDEN NAME First <i>Zada</i> Middle <i>Hartzell</i> Last <i>Hartzell</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year and date of service)				16b SOCIAL SECURITY NO <i>17-07-105</i>		17 INFORMANT <i>Edward M. Giarth</i>				Address <i>13902</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY <i>5149</i> IMMEDIATE CAUSE (a) <i>choledocholithiasis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE PERIOD BETWEEN ONSET AND DEATH <i>11 days</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Biliary colic</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)								
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> to <i>8-1</i> 1968, that (I) (we) saw the deceased alive on <i>8-1</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE <i>D. L. Bucy / S. N. Jones</i>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>8-1-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>D. L. Bucy / S. N. Jones</i>		22e. ADDRESS <i>809 Veins Mill Rd Rockville Md</i>										
23a. BURIAL CREMATION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Burial-transit		23b. DATE <i>8/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Altoona, Ga.</i>				
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		Rockville, Md.		RECORDED BY REGISTRAR <i>Rockville, Md.</i>				25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>				
DATE <i>AUG 5 1968</i>												





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11722

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

729

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <u>JOSEPH T GILLEN JR</u>			2a. DATE OF DEATH Month Day Year <u>Aug 22 1968</u>			2b. HOUR Min <u>2:30</u> AM	
3 SEX <u>MALE</u>		4 RACE <u>W H</u>		5 DATE OF BIRTH <u>April 22 1914</u>		6 AGE in years (last birthday) <u>54</u> YRS.	
7a BIRTHPLACE (State or foreign country) <u>WAYNE PA.</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>MONTGOMERY</u>	
10 CITY OR TOWN OF DEATH <u>BETHESDA</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban</u>		2a USUAL OCCUPATION (Kind of work done during most of working life even if retired) <u>SALESMAN</u>		2b KIND OF BUSINESS OR INDUSTRY <u>General Hospital</u>	
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <u>MARYLAND</u>		13b COUNTY <u>Montgomery</u>		13c CITY OR TOWN <u>Kensington</u>		3a INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13d STREET AND NUMBER <u>4511 SAUL RD</u>		14 FATHER'S NAME First Middle Last <u>JOSEPH T GILLEN</u>		15 MOTHER'S MAIDEN NAME First Middle Last <u>CATHERINE EARLY</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/No or Unknown) <u>NO</u>		16b SOCIAL SECURITY NO <u>145-145-161</u>		17 INFORMANT <u>HILLER B GILLEN wife</u>		Address <u>SAME</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction, old and recent</u> <u>4107</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary thrombosis, old and recent</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>Advanced Coronary arteriosclerosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years &amp; -sudden</u> <u>Years &amp; sud</u> <u>Years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, name medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19 64</u> to <u>Aug. 22 1968</u> that (I) (we) last saw the deceased alive on <u>Aug. 12 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <u>Charles J. Savarese, Jr.</u>				22c. DATE SIGNED <u>8/22/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, JR.</u>		22e. ADDRESS <u>11125 Rockville Pike Rockville, Maryland</u>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL, SPENDING <u>Burial</u>		23b. DATE <u>8-26-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Conshohocken, Penna.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMTHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial/cremation or removal and in any event within 72 hours after death.

Item 22a Film 405 9-2 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
117223		DECEASED NAME (Type or Print)		First Middle Last <i>Yolanda Hornick Goldensky</i>		2a DATE KNOWN OF DEATH Month Day Year <i>Aug 14 1968</i>		2b MOLR <i>3:50 PM</i>	
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>8-3-23</i>	6 AGE (In years last birthday) <i>45</i> YRS	7 IF INDEX YEAR MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year <i>August 14 1968</i>		2d MOLR <i>3:50 PM</i>		
7a BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>		Md.	
9 CITY OR TOWN OF DEATH <i>Bethesda</i>		1 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hickman</i>		2a USAR, OCCUPATION (Kind of work done during most of working life, even if retired)		2b KIND OF BUSINESS OR INDUSTRY			
13a USAR RESIDENCE (Where deceased lived, if institution residence be given admission) STATE <i>Maryland</i>		3b COUNTY <i>Montgomery</i>		3c CITY OR TOWN <i>Bethesda</i>		3d INSIDE TELEPHONE YES <input type="checkbox"/> NO <input type="checkbox"/>		3e STREET AND NUMBER <i>7118 Plantation Drive</i>	
4 FATHER'S NAME First Middle Last <i>Isaac Hornick</i>		5 MOTHER'S MAIDEN NAME First Middle Last <i>Mollie Hornick</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/>		16b SOCIAL SECURITY NO		17 INFORMANT <i>MELVIN Goldensky</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Overdose, mixed, Tofranil, Nembutal and Flacidyl</i> DUE TO OR AS A CONSEQUENCE OF (b) <i>4 days</i> DUE TO OR AS A CONSEQUENCE OF (c) <i>4 days</i>		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		19 DATE OF OPERATION		19b OPERATION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
2a EXTERNAL CAUSE WAS PRESENT OR CONTRIBUTING CAUSE OF DEATH		2b TIME OF INJURY Month Day Year <i>Aug 10 1968</i>		2c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18) <i>Took overdose of drugs</i>		2d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		2e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>	
2f LOCATION Street or R.F.D. No <i>7118 Plantation Drive</i>		City or Town <i>Rockville</i>		County <i>Montgomery</i>		State <i>MD</i>			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>Aug 15, 1968</i>	
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>John G. Ball</i>		ADDRESS (Street, city, town, or county)					
23c BURIAL, CREMATION, REINTERMENT (Specify)		23a DATE <i>8/16/68</i>		23b NAME OF CEMETERY OR CREMATORY <i>KING DAVID MEM GARDEN</i>		23d LOCATION (City or Town) <i>FALLS CHURCH</i>		(County) <i>Va</i>	
24 FUNERAL DIRECTOR <i>B. DANZANSKY &amp; SONS</i>		ADDRESS <i>301-14th St N.W. WASH D.C.</i>		25a REC'D BY REGISTRAR <i>AUG 19 1968</i>		25b REGISTRAR'S SIGNATURE <i>John G. Ball</i>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 in the funeral director's Page 4 should be forwarded to the Chief Medical Examiner's Office along with form. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11724

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

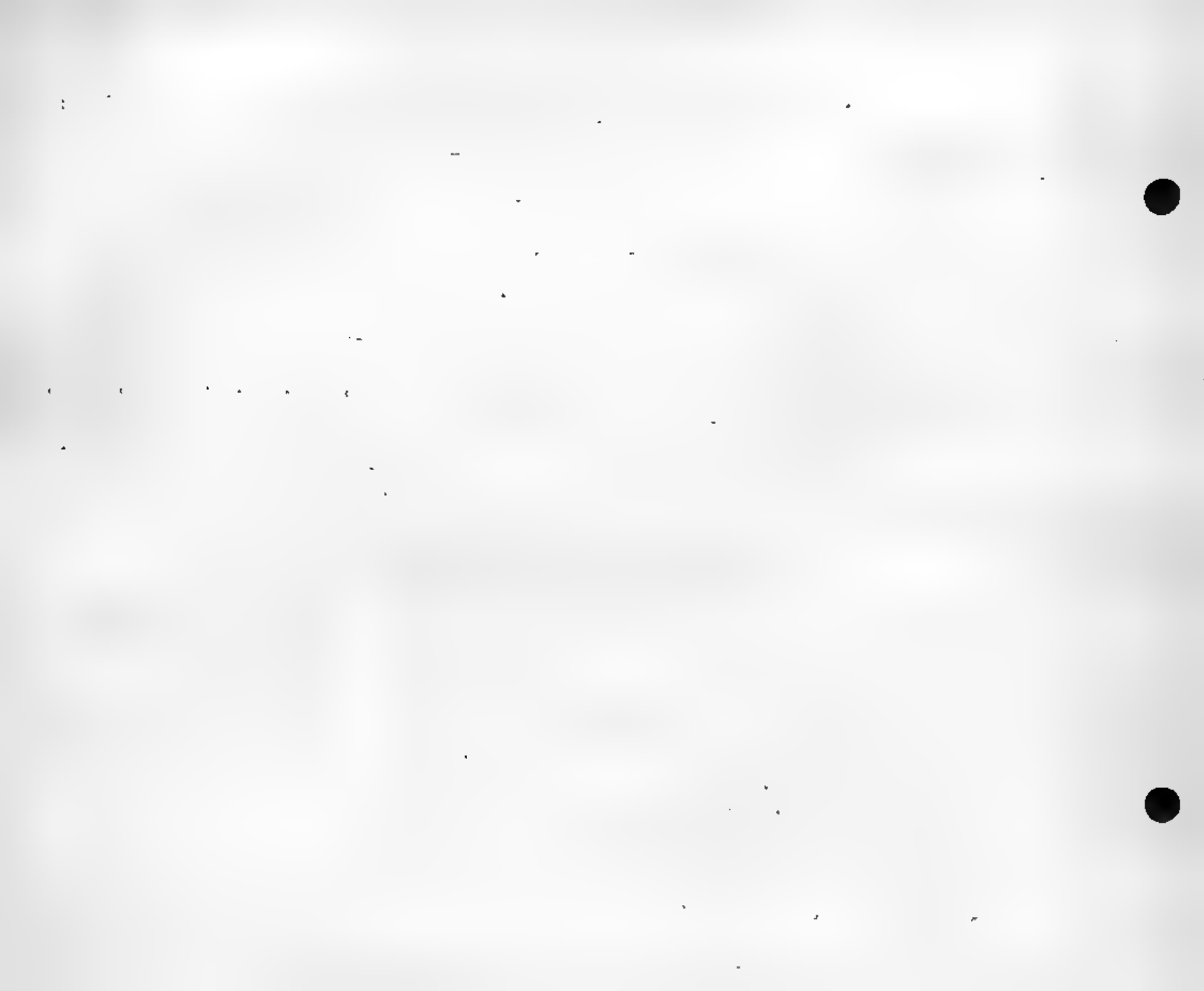
1 DECEASED NAME (Type or Print) <b>JOHN C. GRANGER</b>			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST <b>8-31</b> 19 <b>68</b>		2b HOUR <b>2:55</b> AM
3 SEX <b>M</b>	4 RACE <b>CAUC</b>	5 DATE OF BIRTH <b>10-25-1896</b>	6 AGE <b>71</b> YRS	7 UNDER 4 HRS MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD <b>8-31</b> Year <b>68</b> 2d HOUR <b>2:55</b> AM
7a BIRTHPLACE (State or foreign country) <b>Scotland</b>		7b CIT ZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 CITY OR TOWN OF DEATH <b>Silver Spring</b>		NAME OF HOSPITAL OR INST. (If not in hospital, give street address) <b>8716 Colesville Road</b>		2a USUAL OCCUPATION Kind of work done <b>Sheet Metal Worker</b>	
13a USUAL RESIDENCE (Where he resided admission) STATE <b>MD</b>		3b COUNTY <b>Montg. SIL. SPR.</b>		2c KIND OF BUSINESS OR INDUSTRY <b>Sheet metal</b>	
14 FATHER'S NAME First <b>John</b> Middle <b>Granger</b> Last <b>Granger</b>		5 MOTHER'S M A DEN NAME First <b>Mary</b> Middle <b>McMillian</b> Last <b>McMillian</b>		3c STREET AND NUMBER <b>8716 Colesville Rd.</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b SOC AL SECURITY NO <b>579-40-7675</b>		17 INFORMANT <b>Annie Margaret Granger</b> ADDRESS <b>Sil. Spr., Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per Part 1. Death was CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Emphysema</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Heart Disease</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>492</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		2b TIME OF INJURY Month Day Year <b>19</b> HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18,	
2d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21a PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Beloen R. Read</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <b>8/31/1968</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. READ MD</b>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b DATE <b>9-4-1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Parlawn Cemetery</b>	
24 FUNERAL DIRECTOR <b>M. Andrew Duwall</b>		25a REC'D BY REG STRAR <b>SEP 5 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

VR 415 (1)  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
DECEASED NAME (Type or print)			First <b>IRENE</b>	Middle <b>SARAH</b>	Last <b>GRAY</b>	2a. DATE OF DEATH Month <b>8</b> Day <b>18</b> Year <b>68</b>		2b. HOUR <b>8:15 PM</b>	
3 SEX <b>FEMALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>4-2-89</b>		6. AGE (in years last birthday) <b>79</b> YRS.		7. UNDER YEAR MONTHS # UNDER 24 HRS. MONTHS # UNDER 24 HRS. DAYS # UNDER 24 HRS. HOURS # UNDER 24 HRS. MIN.	
7a. BIRTHPLACE (Store or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General Hospital</b>		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
3a. U.S.A. RESIDENCE (Where deceased lived, if institution. Res. den. before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		3. CITY OR TOWN <b>Monrovia</b>		3d. INSURE CITY (INSURE) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3e. STREET AND NUMBER <b>RFD #1</b>	
14. FATHER'S NAME First <b>James</b> Middle <b>Gaither</b> Last <b>Powell</b>			15. MOTHER'S MAIDEN NAME First <b>Katherine</b> Middle <b>Powell</b> Last <b>Powell</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no. or unknown) <b>no</b> (If yes give year or date of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Admission Record, Mont. Gen. Hospital, Olney, Md</b>					
18. CAUSE OF DEATH (Enter any one cause per use law (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4127</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral pneumonitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b> <b>10 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <b>422</b>									
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>9</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/76</b> to <b>8/18</b> , 19 <b>68</b> , that (I) (the) last saw the deceased alive on <b>8/18</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death									
22b. SIGNATURE <b>James P. Kerr M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/20/68</b>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>8-22-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>MT. ZION Montg Md.</b>			
24. FUNERAL DIRECTOR <b>Robert L Snowden Rockville, Md.</b>		ADDRESS		25a. RECEIVED BY REGISTRAR <b>AUG 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER- This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with Form-2403. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR- Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11728

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201

11733

MEDICAL EXAMINER'S CERTIFICATE OF DEATH GARLAND TEDDY GREEN

DECEASED NAME (Type or Print) <b>Garland TEDDY GREEN</b>			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED <b>8-31-68</b>			2b HOUR <b>10:55</b>		
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>10-7-09</b>	6 AGE in years last birthday <b>58</b> YRS	7 IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	8 UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c DATE PRONOUNCED DEAD <b>8-31-68</b>			2d HOUR <b>10:55</b>		
7a BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 COUNTY OF DEATH <b>MONT. CO.</b>		
10 CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>			NAME OF HOSPITAL OR INSTITUTION, if not in hospital give street address <b>7318 CARROLL AVE</b>			12a SOCIAL OCCUPATION (Kind of work done during week of work no. to even if retired)			12b KIND OF BUSINESS OR INDUSTRY <b>GAS STATION</b>		
3a U.S.A. RESIDENCE, where deceased lived, if institution Residence before admission STATE <b>MD.</b>			3b COUNTY <b>MONT. CO.</b>			3c CITY OR TOWN <b>TAKOMA PARK</b>			3d STREET AND NUMBER <b>7318 CARROLL AVE</b>		
4 FATHER'S NAME First Middle Last <b>HOWARD GREEN</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>ALICE</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b SOCIAL SECURITY NO <b>228-05-9269</b>			17 INFORMANT ADDRESS <b>DRIVERS LICENSE</b>					
8 CAUSE OF DEATH Enter only one cause per item (a) and (b) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Heart Disease</b> DUE TO OR AS A CONSEQUENCE OF (c) <b></b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>											
19a DATE OF OPERATION			9b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			2 b TIME OF INJURY Month Day Year <b>9</b> HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
2 d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, arm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that I took charge of the remains described above and an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Belden R. Keap</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <b>8/31/1968</b>					
EXAMINER'S NAME Type <b>BELDEN R. KEAP MD.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS Street City Town or Suburb <b>Washington DC</b>					
23a SURVEILLANCE BY MEDICAL EXAMINER <b>Sept 4-1968</b>			23b DATE			23c NAME OF CEMETERY OR CREMATORY <b>Catholics</b>			23d LOCATION City or Town County State <b>Washington DC</b>		
24 FUNERAL DIRECTOR <b>Arthur Walters</b>			25a RECEIVED BY REGISTRAR <b>SEP 6 1968</b>			25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11727 CERTIFICATE OF DEATH 11734									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Hattie Gertrude Greenstreet						August 16 1968		M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. UNDER 24 HRS	
Female		White		Sept. 8, 1895		72 VRS		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Baltimore, Md.		U. S. A.				Montgomery Co. Md.		Md.	
10. CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Burtonsville		15101 Birmingham Drive		Saleslady		Retail Store			
13a USJA. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d HOUSE NO. APTS. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Anne Arundel		Brooklyn Park				4036 Belle Grove Rd. 21225	
14. FATHER'S NAME			15 MOTHER'S M A DEN NAME						
First Middle Last			First Middle Last						
Moses A. Webster			Harriett Jory						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
NO		216-32-3219		Mrs. M. June Prewitt		15101 Birmingham Dr. Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CVA</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sen arteriosclerosis</u>									
DUE TO OR AS A CONSEQUENCE OF (c) <u>lost</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
<u>Myocardial infarction severe</u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a ALTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? If either, notify medical examiner		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No		City or Town		County State	
22a I certify that (1) (the hospital) attended the deceased from <u>the</u> 19 <u>68</u> to <u>8-8</u> 19 <u>68</u> that ( ) (we) lost saw the deceased on <u>8-8</u> 19 <u>68</u> , and that (my) (our) opinion on death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>H. G. Summers</u>		<u>8-16-68</u>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
<u>H. G. Summers</u>		<u>1101 Park Avenue N</u>							
23a BIRTH, CREMATION, REMOVAL, ETC.		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION City or Town County State			
Burial		8/19/68		Cedar Hill Cemetery		Ritchie Highway Anne Arundel Md.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
<u>M. C. Culley</u>		<u>F. H. -237 Petapsco Ave. 21225</u>		DATE <u>AUG 19 1968</u>		<u>W. J. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

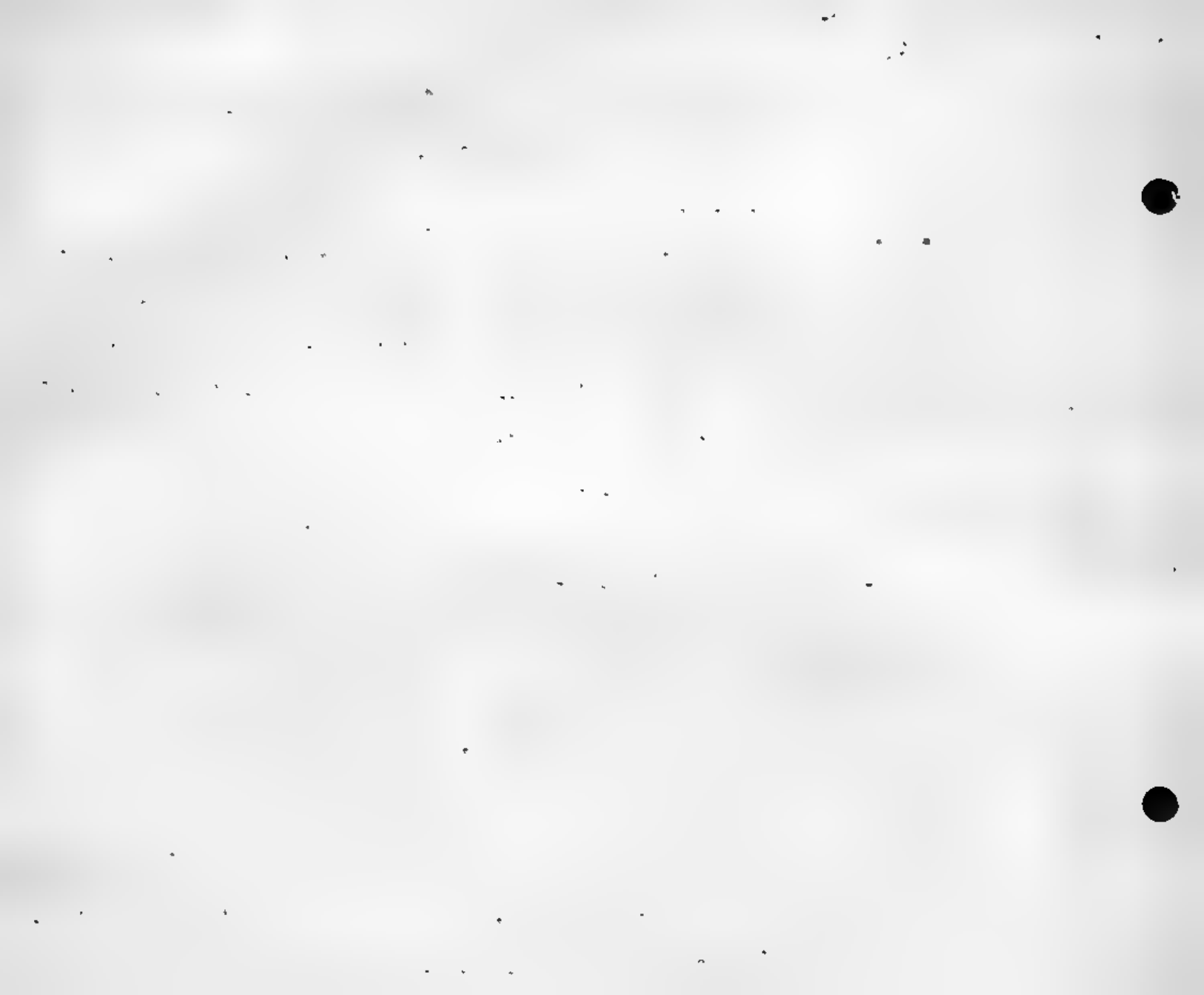
MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Henry Hurter Grosse						Month Day Year August 21 1968			9:00 A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER YEAR		7. UNDER 24 HRS		
Male		White		18 December 1927			40		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland			USA						Montgomery			Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION Kind of work done during most of work week, even if retired.			12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda			The Clinical Center			Manager			Bank				
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission, STATE)			13b. COUNTY			13c. CITY OR TOWN			3d. INSIDE CITY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3e. STREET AND NUMBER	
Maryland			Montgomery			Germantown						113B 23013 Ridge Rd. P. O. Box	
4. FATHER'S NAME First Middle Last			5. MOTHER'S MAIDEN NAME First Middle Last										
Ernest Grosse			Susan Winsch										
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service)			6b. SOCIAL SECURITY NO			17. INFORMANT			Address				
Yes 1950-1952			577-32-9506			The Medical Record			The Clinical Center, NIH, Bethesda, Md. 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>													
1729 DUE TO, OR AS A CONSEQUENCE OF													
(b) <u>Metastatic Malignant Melanoma</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>6 years</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a),													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>8 July</u> 19 <u>68</u> , to <u>21 August</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>21 August</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE <u>Peter G. Burk MD</u>						22c. DATE SIGNED <u>21 August 1968</u>							
22d. PHYSICIAN'S NAME (Type) <u>Peter G. Burk, M.D.</u>						22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>							
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (If by or Town, (County) (State)				
Burial			Aug. 24, 1968			S. Perkasio Evangelical			S. Perkasio Pa.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Olin L. Molesworth, Damascus, Md.						DATE <u>AUG 27 1968</u>			<u>Charles Jones</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
11725											
736											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR			
First <i>William</i> Middle <i>Groves</i> Last <i>Groves</i>						Month <i>Aug.</i> Day <i>20</i> Year <i>1968</i>		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		June 19, 1894		74 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U. S. A.				Montgomery		Md.			
10. CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (If none, give street address)		11. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Nursing Home		Bus Operator		D. C. Transit					
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)		13b. CITY OR TOWN		13c. STREET AND NUMBER		13d. INSIDE CITY LIMITS?					
Silver Spring		Silver Spring		703 Garner Ave.		YES <input type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
William Groves				Josephine Southard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
Yes		578-10-5941A		Mrs. Alma Groves		2703 Parker Ave. Sil. Spr. Md.					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis										1 month	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio-Vascular Disease 3 years											
DUE TO, OR AS A CONSEQUENCE OF (c) Urinary Tract Infection										1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Parkinson's Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
OR CONTRIBUTING CAUSE OF DEATH (If either notify medical examiner)		HOUR A.M. Month Day Year									
22a. INJURY OCCURRED		22b. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING ETC)		22c. LOCATION		Street or R.F.D. No		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from Nov. 17, 1966 to Aug. 20, 1968, that (I) (we) last saw the deceased alive on Aug. 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN		MED. DIRECTOR		STAFF PHYSICIAN	
William Brainin						<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		22f. DATE SIGNED		22g. REGISTRAR'S SIGNATURE			
WM BRAININ				6056 Central Ave, Capital Hyts Bldg		5/20/68		Charles Judge			
23a. BURIAL CREMATION		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		8-23-68		Rock Creek Cemetery		Washington				D. C.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE			
C. Glen Carter				AUG 26 1968		Charles Judge					
Garner E. Humphrey, Inc. 8434 Ga. Ave., Sil. Spr. Md.											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

11730

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

737

DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
MARY		K.	HAGNER		8 Month 8 Day 1968		8:45 P M	
3 SEX	4. RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		11 UNDER 1 YEAR	
FEMALE	WHITE		JAN. 8, 1886		82 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
BAVARIA		U.S.				MONTGOMERY		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
KENSINGTON		KENSINGTON GARDENS SANITARIUM		HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INVOICE CITY, MARYLAND		13e. STREET AND NUMBER
M.D.		PRINCE GEORGES		HYATTSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3403 STANFORD STREET
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
KREIGEL		LINK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes No. or unknown (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT				
NO				WALTER HAGNER 13102 VAN DALLA DRIVE WHEATON, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL ARTERIOSCLEROSIS								6 MONTHS
DUE TO, OR AS A CONSEQUENCE OF (b) GENERAL ARTERIOSCLEROSIS								SEVERAL YEARS
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS								2 YEARS
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
AURICULAR FIBRILLATION, CHRONIC HYPERTENSION, CHRONIC EST.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
OR CONTRIBUTING CAUSE OF DEATH (If neither, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>								
22a. I certify that (1) (this hospital) attended the deceased from FEB 19, 1957, to AUG. 8, 1968 that (1) (we) last saw the deceased alive on AUGUST 8, 1968, and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (d) (did not) view the body after death								
22b. SIGNATURE				22c. DATE SIGNED				
James A. Roberts M.D. DEGREE				AUGUST 8, 1968				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
JAMES A. ROBERTS				8907 GEORGIA AVE SILVER SPRING, MD				
23a. BURIAL CREMATION, REMAINS (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Aug 12, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons Hyattsville, Md.				DATE AUG 12 1968		Charles Judge		



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

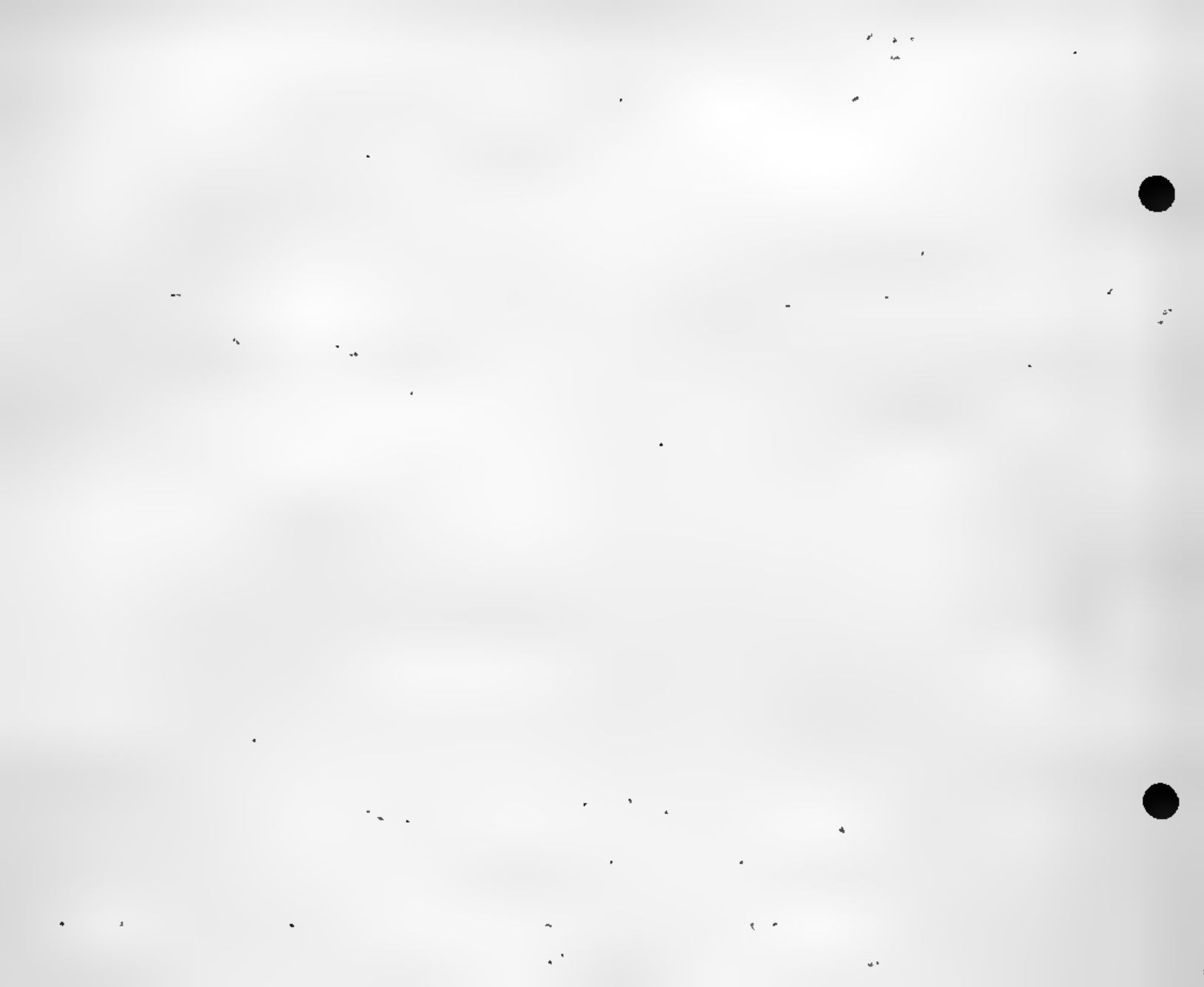
11731

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11738

# CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <b>Mamie Cordelia Harrell</b>			2a. DATE OF DEATH <b>8 Month 31 Day 1968 Year</b>		2b. HOUR <b>8:50 A M</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>6-29-1894</b>		6 AGE (In years last birthday) <b>74</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>America</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Montgomery</b> Md		
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sen + Hospital</b>		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. U.S.A. RESIDENCE Where deceased lived, + institution Residence before admission) STATE <b>Maryland</b>	3b. COUNTY <b>Montgomery</b>	3c. CITY OR TOWN <b>Spencerville</b>	3d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>"</b>	
4. FATHER'S NAME First Middle Last <b>Thomas H Burriss</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Mary E AGNES Grey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>213-12-6291P</b>		16b. SOCIAL SECURITY NO <b>213-12-6291P</b>		17 NEOMANT <b>Charlie Harrell</b> Address <b>Same as 13</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Bronchopneumonia, Diabetes mellitus</b>					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, buildings, etc.)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1961</b> to <b>8/31 1968</b> , that (I) (we) last saw the deceased alive on <b>8/30 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Joseph E. Smith, Jr. M.D.</b>		22c. DATE SIGNED <b>8/31/68</b>		22d. ADDRESS <b>Burtonsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 3, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Burtonsville</b>	
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 4 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay in its execution should be reported to the State Health Department. If necessary, please execute the certificate within the word pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the funeral director's report. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Health Department at the time of burial, cremation, or removal and in any event within 72 hours after death.

11732		DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201		~39	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1 DECEASED NAME (Type or Print)		F. S. Middle Last		2a DATE KNOWN OF DEATH	
Louis Thomas Harris				Month Day Year	
3 SEX		4 RACE		5 DATE OF BIRTH	
M.		Negro		Oct. 15, 1964	
6 AGE in years		7b SEX OF DEATH		8 DATE PRONOUNCED DEAD	
3 YRS		M. F.		Month Day Year	
7a BIRTHPLACE (State or foreign country)		7b T. ZEN OF WHAT COUNTRY?		8 MARRIED	
P.		U.S.A.		NEVER MARRIED	
10 CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION		9 COUNTY OF DEATH	
Bethesda		Suburban		Montgomery	
3a SOCIAL RESIDENCE (Where deceased lived if not in hospital)		3b CITY OR TOWN		12a USUAL OCCUPATION (Kind of work done during most of working life)	
Mel.		Montgomery Poolsville		12b KIND OF BUSINESS OR INDUSTRY	
4 FATHER'S NAME		5 MOTHER'S MAIDEN NAME		13a STREET AND NUMBER	
Morris Benjamin Harris		Mattie Herbert		10800 Sugarland Rd.	
16a WAS DECEASED EVER IN U.S. ARMED FORCES?		6b SOCIAL SECURITY NO		17 INFORMANT	
(Yes, no, or unknown)				ADDRESS	
8 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia.					
DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration of Gastric Contents.					
DUE TO, OR AS A CONSEQUENCE OF (c) ...					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
725					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY (Month, Day, Year)		22 HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 8)	
		10-15-68		Stripped from car ground neck	
23a NATURE OF INJURY		23b PLACE OF INJURY (Home, arm, street, factory, office building, etc.)		24 LOCATION OF INJURY (City, Town, County, State)	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Same address as above 10800 Sugarland Rd.	
22a I certify that took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b DATE SIGNED	
John B. Bell				Aug 27, 1968	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city, town, or county)	
23a BURIAL, CREMATION, or other disposition		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		8-29-68		Lincoln Park Cem.	
24 FUNERAL DIRECTOR		24a REC'D BY REG. STRAR		24b REG. STRAR'S SIGNATURE	
Robert L. Snowden		SEP 3 1968		Charles J. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 4-68  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>James Thomas Hatfield, Jr</i>					2a DATE OF DEATH Month <i>Aug</i> Day <i>26</i> Year <i>'68</i>		2b HOUR <i>3:25</i> PM		
3 SEX <i>male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>Aug 26, 1968</i>		6 AGE (in years last birthday) <i>YRS.</i>		7 MONTHS <i>7</i> DAYS <i>35</i>	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban Hosp</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Bayde</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>Box 38 Route 21, White Mount Md</i>	
4. FATHER'S NAME First <i>James</i> Middle <i>Thomas</i> Last <i>Hatfield</i>		5. MOTHER'S MAIDEN NAME First <i>Diana</i> Middle <i>Catherine</i> Last <i>Washburn</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT <i>Birth certificate</i> Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory &amp; Vascular Collapse</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Immaturity (severe Prematurity)</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1</i> Conditions, if any, which gave rise to immediate cause or, stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> <i>6 hrs.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>7735</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/26</i> 19 <i>68</i> to <i>8/26</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8/26</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <i>Thomas C. Benja</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>8/27/68</i>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL, SPECIFY		23b. DATE <i>8-29-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Wheaton, MD.</i>			
24. FUNERAL DIRECTOR <i>James E. D. V. H.</i>		24a. DATE <i>SEP 3 1968</i>		24b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial or cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or print)			First <b>Inez</b>			Middle <b>Mayo</b>			Last <b>Hawkins</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1968</b>		2b. HOUR <b>8:10</b> AM	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Feb. 24, 1877</b>				6. AGE (In years last birthday) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS <b>8</b> DAYS <b>12</b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>			
7a. BIRTHPLACE (State or foreign country) <b>Tennessee</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.						
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Asbury Methodist Home</b>				2a. USJA OCCUPATION (Kind of work done during most of working life, even if retired) <b>Office work</b>				2b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>				
3a. USJA RESIDENCE (Where deceased lived at time of death) <b>District of Columbia</b>			12. CITY OR TOWN <b>Washington</b>			3b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4325 Van Ness St., N. W.</b>							
4. FATHER'S NAME First <b>B.</b> Middle <b>H.</b> Last <b>Mayo</b>			5. MOTHER'S MAIDEN NAME First <b>Julia</b> Middle <b></b> Last <b>Robinson</b>												
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>			16b. SOCIAL SECURITY NO. <b>579-60-6669-T</b>			17. INFORMANT Address <b>Asbury Methodist Home, Gaithersburg, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4337 Spontaneous pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF <b></b> (c) <b></b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>2 mos.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)															
9a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part or Part 2 Item 18.)								
22a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				22b. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>4/1/68</b> , 19 to <b>8/13/68</b> , 19 that (i) (we) lost saw the deceased alive on <b>8/13/68</b> , 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death															
22b. SIGNATURE <b>Henry C. Scruggs</b>			DEGREE <b>M. D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/13/68</b>						
22d. PHYSICIAN'S NAME (Type) <b>Henry C. Scruggs M. D.</b>			22e. ADDRESS <b>5413 Cedar Lane Bethesda, Md.</b>												
23a. BURIAL OR CREMATION <b>Burial</b>			23b. DATE <b>8-17-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>West View Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Sweetwater Tenn.</b>						
24. FUNERAL DIRECTOR <b>Bert A. Pumphrey</b>			ADDRESS <b>Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

11735

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Alton		M	Heinbuch		MAY 8 3 1968		8	3	1968	9:35A
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE	IF UNDER 1 YEAR	IF UNDER 24 HRS		2c. DATE PROBABLE OF DEATH		2d. HOUR
Male	White	10/23/04		63 YRS	MONTHS	DAYS	HOURS	MIN.	8	3 1968 9:35A
7a. BIRTH PLACE (State or origin country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Arlington Va.		USA				Montgomery		Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		2b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring		Holy Cross Hospital		Shipping clerk		American Stores				
3a. USUAL RESIDENCE (Where deceased lived in institution, residence before admission)		3b. COUNTY		3c. CITY OR TOWN		3d. HOUSE CITY LIMITS		3e. STREET AND NUMBER		
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16006 Sycamore Lane		Rockville
4. FATHER'S NAME		First	Middle	Last	15. MOTHER'S M maiden name		First	Middle	Last	
John		Conrad	Heinbuch		Mary		Elizabeth	Dye		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
no		577 07 6494		wife		Eloise I. 16006 Sycamore Lane		Rockville, Md.		
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) 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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11738 CERTIFICATE OF DEATH 743									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
BETTIE LEE HICKS						8 Month 20 Day 68 Year		11:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE in years last birthday		7. IF UNDER YEAR	
Female		White		9-9-90		77 YRS		MONTHS DAY HOURS MINS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
TEXAS		U.S.A.				Montgomery County			
10. CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		Washington Suburban Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery Co		Germantown		YES <input type="checkbox"/> NO <input type="checkbox"/>		RT #1 Meadow Brook Estate	
14. FATHER'S NAME First Middle Last			15. MOTHER'S M A D E N NAME First Middle Last						
Henry Rowe			Martha Conway						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes. NO. or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		466-12-1983		Pt. Record					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 2 DEATH WAS CAUSED BY IMMEDIATE CAUSE a) <u>Myocardial infarction</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days 10 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Coronary artery disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
8-19-68		Transcatheter aortic valve replacement		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-7-1959 to 1-10-1968 that (I) (we) last saw the deceased alive on 1-19-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death									
22b. SIGNATURE		22c. DATE SIGNED		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Seruch T. Kimble		9801 Ga. Ave., Silver Spring, Md.							
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Aug. 24, 1968		Blocker Cemetery		Marshall Harrison Texas			
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. RECD BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home		1391 Rockville, Pike Rockville, Md.		DATE AUG 22 1968		J. Charles Judge			



11737

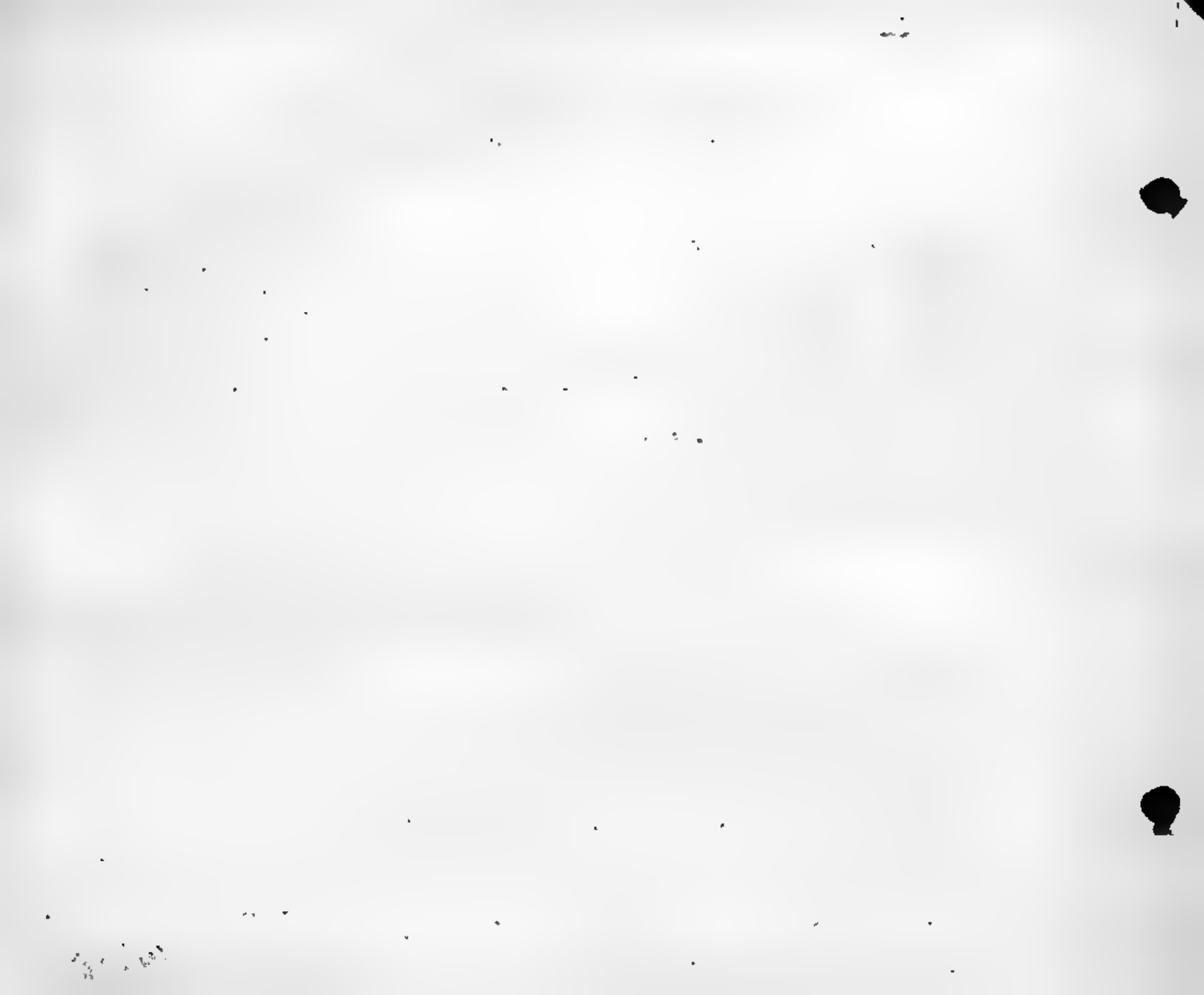
## CERTIFICATE OF DEATH

744

1 DECEASED NAME (Type or print) Della A Higby			2a DATE OF DEATH Aug 9 1968 Month Day Year			2b HOUR 1:27 PM					
3 SEX female		4 RACE white		5 DATE OF BIRTH Jan 23, 1880		6 AGE (in years last birthday) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.					
10 CITY OR TOWN OF DEATH TAKOMA PARK			1 NAME OF HOSPITAL OR INSTITUTION (I not in hospital give street address) WASHINGTON SAN HOSP			2a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			2b KIND OF BUSINESS OR INDUSTRY none		
13a U.S.A. RESIDENCE (Where deceased lived at least 1 year before death) Maryland			13b COUNTY Prince George		3 CITY OR TOWN Upper Meridian		13c STREET AND NUMBER 402 VAN BUREN ST.				
14 FATHER'S NAME First Middle Last Oliver W Custead			5 MOTHER'S MAIDEN NAME First Middle Last Minerva Hamilton								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b SOCIAL SECURITY NO 177 03 7345B		17 INFORMANT Address Ruth Haver Dau. Same as above						
18 CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> (Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 5/1/77		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 9			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f LOCATION Street or RFD No. City or Town County State					
22a I certify that (I) (th s hospital) attended the deceased from <u>Aug 9, 1968</u> to <u>Aug 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d.d) (did not) view the body after death											
22b SIGNATURE Myron L. Lenkin						22c DATE SIGNED 3/1/68					
22d PHYSICIAN'S NAME (Type, Myron L. Lenkin						22e ADDRESS 2309 Sherfield Road, Wheaton, Md.					
23a B.U.R.A. CREMATION REMOVAL (Specify, Burial)			23b DATE 8/12/68		23c NAME OF CEMETERY OR CREMATORY Greendale Cemetery			23d LOCATION City or Town, (County) State, Crawford Penna.			
24 FUNERAL DIRECTOR F. Gasch's Sons						ADDRESS Hyattsville, Maryland		25a REC'D BY REGISTRAR DATE AUG 12 1968		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attend physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Five pages (and 2 with the State Department of Health) prior to burial, cremation or removal and in any event within 72 hours after death.

11735

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Florence Elizabeth Hill			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8-5-1968			2b HOUR 11:05 PM		
3 SEX F	4 RACE W	5 DATE OF BIRTH 3/16/23	6 AGE 45 YRS	7 FINDER MONTHS	8 DAYS	9 HOURS	10 MIN	2c DATE PRONOUNCED DEAD Month 8 - Day 5 - Year 1968
7a BIRTHPLACE (State or foreign country) D.C.		7b CITIZEN OF WHAT COUNTRY? Amer.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Co.		
10 CITY OR TOWN OF DEATH Takoma Park			NAME OF HOSPITAL OR INSTITUTION (if not in hospital) Wash. San. & Hosp.			2a USUAL OCCUPATION Kind of work done during mos. of work no. 1e even if retired Housewife		2b KIND OF BUSINESS OR INDUSTRY
13a U.S.A. RESIDENCE Where deceased lived, if institution or residence before admission STATE Md.			13b COUNTY Prince Georges			13c CITY OR TOWN Hyattsville		3e STREET AND NUMBER 5707 Chillum Hgts. Dr.
14 FATHER'S NAME First Middle Last Mosely			15 MOTHER'S MAIDEN NAME First Middle Last			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16b SOCIAL SECURITY NO unknown			17 INFORMANT Patient's chart			ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c); PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Glomerulonephritis with Renal Failure secondary to Essential Hypertension accompanied by Massive Acute Cerebral Hemorrhage								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 31X								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 ALFOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21a TIME OF INJURY Month, Day, Year Hour, A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18.)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State		
22a I certify that I took charge of the remains described above held on death resulted from Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE BELOON R. REAP MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED Aug. 6, 1968		
23a BURIAL OR REMOVAL SPECIFY			23b DATE			23c NAME OF CEMETERY OR CREMATORY		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR DATE AUG 7 1968		
						25b REGISTRAR'S SIGNATURE Charles J. Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

11730

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

746

1. DECEASED NAME (Type or print) <b>ESTELLE Henrietta HINMAN</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1968</b>			2b. HOUR <b>10:50</b> AM	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>January 20, 1889</b>		6. AGE (In years last birthday) <b>79</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Carroll Hall Sanitarium</b>		12a. USUAL OCCUPATION (Kind of work done during most of work ng. (e. even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. STREET AND NUMBER <b>9209 La Velle Drive</b> <b>10251 Carroll Place</b>			
4. FATHER'S NAME First Middle Last <b>John V. Steger</b>			5. MOTHER'S MAIDEN NAME First Middle Last <b>Louise (Unknown)</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>***</b>		16b. SOCIAL SECURITY NO <b>Not Available</b>		7. INFORMANT <b>9209 La Velle, Mrs. Joseph P. Baker, Chevy Chase, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO: OR AS A CONSEQUENCE OF (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO: OR AS A CONSEQUENCE OF (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> Conditions if any which gave rise to immediate cause (a) stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1, (a) <b>PARKINSON'S DISEASE</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH If either notify medical examiner		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME - ARM. STREET - FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>August 16 1968</b> to <b>August 28 1968</b> that (I) (we) last saw the deceased alive on <b>August 28 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <b>Henry M. Louden, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>8/28/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>HENRY M. LOUDEN, M.D.</b>				22e. ADDRESS <b>3206 Parkway Dr. Chevy Chase, Md.</b>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>		23d. LOCATION City or Town, County, State <b>Chicago, Cook, Illinois</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PIMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

11740

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First <i>Ethel</i> Middle <i>Lida</i> Last <i>Lancaster Hobbs</i>			2a. DATE OF DEATH Month <i>August</i> Day <i>2</i> Year <i>1968</i>		2b. HOUR <i>9:35</i> M
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Jan. 3, 1879</i>		6. AGE, in years last birthday, <i>89</i> YRS	IF UNDER YEAR MONTHS DAYS <i>6 29</i>
7a. BIRTHPLACE (State or foreign country) <i>Maine</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		
D. CITY OR TOWN OF DEATH <i>Silver Spring, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>9401 Monroe Street</i>		2a. USUAL OCCUPATION Kind of work done during most of working life to even if retired) <i>Housewife</i>	
3a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	3b. STREET AND NUMBER <i>9401 Monroe Street</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>
14. FATHER'S NAME First <i>George</i> Middle <i>E.</i> Last <i>Lancaster</i>		5. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i>Ellen</i> Last <i>Baker</i>			
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. <i>210-44-8243</i>		17. INFORMANT Address <i>Miss Helen Hobbs 9401 Monroe St., S.E. Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis</i>					<i>22 years</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i>					<i>28 years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic pyelonephritis &amp; prolapsed uterus</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 10, 1940</i> , to <i>Aug. 2, 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug. 2, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>E. Clarence Rice, M.D.</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>August 2, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>E. Clarence Rice, MD</i>		22e. ADDRESS <i>1150 Connecticut Ave., N.W. Wash. D.C.</i>			
23a. BURIAL CREMATION <i>Burial</i>		23b. DATE <i>August 6, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Linwood Cemetery</i>	
23d. LOCATION (City or Town) <i>Weston, Mass.</i>		(County)		(State)	
24. FUNERAL DIRECTOR <i>Warren E. Humphrey, Inc.</i>		ADDRESS <i>8434 Ga., Ave., S.E.</i>		25a. REC'D BY REGISTRAR <i>AUG 6 1968</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11748 CERTIFICATE OF DEATH 748									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Nina Maudella Hodgson						August 27 1968		6:25 A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 24 HRS	
Female		White		23 July 1916		52 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Canada		Canada				Montgomery		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (Not in hospital give street address)				2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		2b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		The Clinical Center, NIH				Secretary		Clerical	
13a. USUAL RESIDENCE (Where deceased lived 1 year or more before admission) STATE				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Washington, D.C.				Washington		YES		Apt. 303 3001 Porter Street, N.W.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Robert J. Hodgson			Alice M. Dean						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT				
No			579-62-9286		Bethesda, Md. The Medical Records, The Clinical Center.				
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).)									18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Progressive Respiratory Failure</u>									3 days
(b) <u>Hemorrhagic Pancreatitis</u>									1 week
(c) <u>Disseminated Adenocarcinoma</u>									6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
8/8/68		Retroperitoneal Tumor		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (a) (this hospital) attended the deceased from <u>3 August 1968</u> to <u>27 August 1968</u> that (b) (we) last saw the deceased alive on <u>27 August 1968</u> , and that in (c) (our) opinion non-death occurred on the date and hour and from the causes stated above. (d) (we) did (did not) view the body after death									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<i>Everett V. Sugarbaker, M.D.</i>								August 27, 1968	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Everett V. Sugarbaker, M.D.				The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) County (State)			
Cremation		28 Aug 68		Cedar Hill Crematory		Suitland, Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawlers Sons				5130 Wisd. Ave. N. W. Washington D. C.		AUG 30 1968 <i>Charles Judge</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

11742

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

11742

1 DECEASED NAME (Type or print) <b>Della M. Holmes</b>			2a. DATE OF DEATH <b>8</b> Month <b>9</b> Day <b>68</b> Year			2b. HOUR <b>2 P.</b>				
3. SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>July 18, 1878</b>		6 AGE (in years last birthday) <b>90</b> YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE State or foreign country <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b> Md.				
10 CITY OR TOWN OF DEATH <b>Kensington</b>			1 NAME OF HOSPITAL OR INSTITUTION (not in hospital give street address) <b>Carroll Hall</b>			2a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>Housewife</b>			2b. KIND OF BUSINESS OR INDUSTRY	
3a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>Maryland</b>			3b. COUNTY <b>Montgomery</b>			3c. CITY OR TOWN <b>Damascus</b>			3d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Amos Cooley</b>			5. MOTHER'S M A DEN NAME First Middle Last <b>Elizabeth Grimes</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes give war or dates of service			16b. SOCIAL SECURITY NO <b>217-48-9408</b>			17 INFORMANT <b>Mrs Ida E. Lowe</b> <b>3506 Farragut Ave. Kensington, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> <b>4</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ARTERIOSCLEROTIC CEREBROVASC DIS.</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 mo</b> <b>YES</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
9a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
2 d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)			2 f. LOCATION Street or RFD No. City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from <b>5/3</b> <b>1968</b> to <b>8/9</b> <b>1968</b> that (I) (we) lost saw the deceased alive on <b>8/9</b> <b>1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death										
22b SIGNATURE <b>Richard H. Pollen</b> MD			22c. ADDRESS <b>10400 CONNECTICUT AV, KENSINGTON Md.</b>			22d. DATE SIGNED <b>8/9/68</b>				
22e. PHYSICIAN'S NAME Type <b>RICHARD H. POLLEN</b>										
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>8/12/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>			23d. LOCATION City or Town (County) (State) <b>Beallsville, Maryland</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</b>						25a. REC'D BY REGISTRAR <b>AUG 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET BALTIMORE, MARYLAND 21201										
11743 Item 10a File										
CERTIFICATE OF DEATH										
DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH		2b HOUR		
Eugene Francis Hourihan						Month August Day 5 Year 1968		2:05 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER YEAR		
Male		White		4 July 1911		57 YRS.		IF UNDER 24 HRS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New Jersey		USA				Montgomery		Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			2a U.S.A. OCCUPATION Kind of work done during past 12 months (even if retired)		2b KIND OF BUSINESS OR INDUSTRY		
Bethesda			The Clinical Center			Auto Dealer		Self-employed		
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)			13b COUNTY		13c CITY OR TOWN		3d INCLUDE CITY UNITS?		3e STREET AND NUMBER	
Washington, DC			DC		Washington, DC		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5050 MacArthur Boulevard	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Michael J. Hourihan			Brigid Driscoll							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		7 INFORMANT The Medical Records Address					
Yes Yea			1942-1946		579-07-8023 The Clinical Center, NIH, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hodgkin's disease involving lymph nodes, liver, spleen, tongue, skin, epididymis										
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)										
Thrombocytopenia										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year								
If either notify medical examiner		P.M. 19								
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)		21f LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		OFFICE BUILDING, ETC								
22a I certify that <del>XX</del> (this hospital) attended the deceased from 17 June 1968 to 5 August 1968 that <del>XX</del> (we) last saw the deceased alive on 5 August 1968, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>XX</del> (we) (did) <del>not</del> view the body after death										
22b SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED		
								5 August 1968		
22d PHYSICIAN'S NAME (Type)				22e ADDRESS						
M. Michael B. Mosher, M.D.				The Clinical Center, National Institutes of Health, Bethesda, Maryland						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)		
Burial		Aug. 8 1968		St. Gertrudes Cemetery		Rahway		New Jersey		
24 FUNERAL DIRECTOR				25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Robert A Pumphrey 7557 Wisc. Ave. Beth				DATE AUG 8 1968						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial or transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Hussie L. Huggins						Month Day Year		9 30 P.M.		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE in years (last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS		
F		W		1/27/1896		72 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
South Carolina		U.S.A.				Montgomery				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INST. TO WHICH DECEASED WAS TAKEN (Kind of work done, give street address)		12. KIND OF BUSINESS OR INDUSTRY						
Bethesda		Grosvenor Lane Nursing Home		RETIRED GIFT WRAPPER DEPT. STORE						
13a. USUAL RESIDENCE (Where deceased lived if institution admission)		13b. COUNTY		3c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		3e. STREET AND NUMBER		
Md		Prince Georges		Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6312-57th Ave.		
4 FATHER'S NAME			5. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle							
Gus Lottis			Mary Hammond							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			7 INFORMANT			Address	
No			579-44-4246			Mrs. Virginia L. Fitzgerald			Hyattsville, Md.	
8. CAUSE OF DEATH Enter on only one cause per line for (a) (b) and (c).										
PART 1. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) Cerebral thromboses										
DUE TO OR AS A CONSEQUENCE OF										
(b) Cerebral arteriosclerosis										
DUE TO OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)										
Parkinson disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)						
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year								
(If either, notify medical examiner)		P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (A HOME, ARM, STREET, FACTORY? OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		
While <input type="checkbox"/> Not while <input type="checkbox"/>										
at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from Aug 16 1968 to Aug 15 1968 that (I) (we) last saw the deceased alive on Aug 16 1968 and that in (my) (our) opinion on death occurred on the date and hour and from the causes stated above, (I) (we) (did, did not) view the body after death										
22b. SIGNATURE		22c. DEGREE		22d. ADDRESS		22e. DATE SIGNED				
Don B. Cameron		M.D.		3503 PERRY ST. MT. RAINIER, MD.		8-19-68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. DATE SIGNED		22g. REGISTRAR'S SIGNATURE				
DON B. CAMERON		3503 PERRY ST. MT. RAINIER, MD.		AUG 21 1968		Charles Judge				
23a. BURIAL PERMIT ON		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		State		
Burial		8-22-68		QUAKER CEMETERY		CAMPDEN		S.C.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
W. W. Chambers		Wash, D. C.		AUG 21 1968		Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																										
11745																										
CERTIFICATE OF DEATH																										
1 DECEASED NAME (Type or print)			First CLARENCE			Middle JULIAN			Last HURLBUT			2a. DATE OF DEATH Month AUGUST			Day 24			Year 1968			2b. HOUR 5:50			P. M.		
3 SEX Male			4 RACE Caucasian			5 DATE OF BIRTH 8-23-1898			6 AGE (in years) 70			7 MONTHS 10			8 YEARS YRS.			9 UNDER 24 HRS. HOURS			10 MIN.					
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH MONTGOMERY																	
10 CITY OR TOWN OF DEATH BETHESDA			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SUBURBAN			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY																	
13a. USUAL RESIDENCE (Where deceased lived, + institution Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN BETHESDA			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 8506 JEFFERSON STREET														
14 FATHER'S NAME First William			Middle Hurlbut			Last Hurlbut			15 MOTHER'S MAIDEN NAME First Emma			Middle Dever			Last Dever											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. 275-05-9780			17 INFORMANT Mrs. Mona L. Hurlbut, same as item 13e																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic Hypertensive Heart Disease</u>																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. 1 YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)																				
22a. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			22c. LOCATION Street or R.F.D. No. City or Town County State																				
22a. I certify that (I) (this hospital) attended the deceased from Aug. 8 1968 to Aug. 24 1968 that (I) (we) lost the deceased alive on Aug. 24 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE <u>Isidore Shulman</u> M.D.			22c. DEGREE DEGREE			22d. ADDRESS 915 19th Street, N. W., Washington, D.C.			22e. DATE SIGNED 8/24/68																	
22d. PHYSICIAN'S NAME (Type) ISIDORE SHULMAN																										
23a. BURIAL CREMATION, REMOVAL, ETC. Burial			23b. DATE 8-27-1968			23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION City or Town (County) State Washington, D.C.																	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.			ADDRESS Washington, D. C.			25a. REC'D BY REG. STRAR DATE AUG 30 1968			25b. REG. STRAR'S SIGNATURE Charles Judge																	

MEDICAL CERTIFICATION





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office and with form PM-5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal and any event within 72 hours after death.

11748										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1953									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1. DECEASED NAME (Type or Print) <b>Brooke</b>					2. DATE KNOWN OF DEATH EST. <b>Aug 19</b> 19 <b>68</b>					2b. MONTH <b>10</b> DAY <b>15</b> YEAR <b>68</b>																			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Oct 14, 1909</b>		6. AGE <b>58</b> YRS		7. IF INJURED BY FIRE		8. IF INJURED BY OTHER		9. DATE PRONOUNCED DEAD Month <b>Aug</b> Day <b>20</b> Year <b>1968</b>		10. CAUSE OF DEATH Month <b>Aug</b> Day <b>20</b> Year <b>1968</b>															
7a. BIRTHPLACE State or foreign country					7b. CITIZENSHIP OF WHAT COUNTRY? <b>U.S.A.</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Montgomery.</b>														
10. CITY OR TOWN OF DEATH <b>Bethesda</b>					11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Carlin Shopping Center</b>					12a. SOCIAL OCCUPATION (kind of work done during most of working life even if retired) <b>Telephone operator</b>					12b. KIND OF BUSINESS OR INDUSTRY														
3a. SOCIAL RESIDENCE Where deceased lived if not on residence before admission STATE <b>Md.</b>					3b. COUNTY <b>Montgomery</b>					3c. STREET AND NUMBER <b>5319 Tuscarawas Rd/</b>																			
14. FATHER'S NAME First <b>Joseph</b> Middle <b>W</b> Last <b>Jackson</b>					15. MOTHER'S MAIDEN NAME First <b>Flora</b> Middle <b>Acker</b> Last <b>Acker</b>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b>					16b. SOCIAL SECURITY NO <b>214-18-0216</b>					17. INFORMANT <b>Elizabeth A. Jackson</b>					ADDRESS <b>Same as Item 12.</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia of Retroperitoneal Abscess</b> <b>561X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Rupture of Cecum</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Colitis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hr</b> <b>4 day</b> <b>7</b>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Chronic Alcoholism</b>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21. CAUSE OF DEATH WAS PRIMARY <input type="checkbox"/> OR ON RIGHT SIDE <input type="checkbox"/>					22. TIME OF INJURY Month Day Year HOUR A.M. P.M. <b>19</b>					23. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 8)																			
24. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					25. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					26. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that I took charge of the remains described above. He died an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <b>John G. Ball</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED <b>Aug 24, 1968</b>																			
EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
					ADDRESS (street, city, town, or county) <b>Bethesda, Md.</b>																								
23a. BURIAL REMOTION (Type and place) <b>Burial</b>					23b. DATE <b>8-24-68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>West End Cemetery</b>																			
					23d. LOCATION (city, town, county, state) <b>Wytheville, Va.</b>																								
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>					25a. RECEIVED BY REG. STRAR <b>AUG 23 1968</b>					25b. REG. STRAR'S SIGNATURE <b>John G. Ball</b>																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation or removal, and no any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>ALLAN</b>						2a. DATE OF DEATH <b>Aug. 22</b> Day <b>22</b> Year <b>1968</b>			2b. HOUR <b>9:00</b> AM		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 15, 1891</b>		6. AGE (In years last birthday) <b>77</b> YRS.		7. MONTH <b>Aug</b>		8. DAY <b>22</b>	
7a. BIRTHPLACE (State or foreign country) <b>Scotland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Potomac Valley Nursing Home</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>1001 Market</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Texas Co</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY (LIMIT) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>7108 Panopama Drive</b>			
14. FATHER'S NAME First <b>William</b> Middle <b>J</b> Last <b>Jamieson</b>				15. MOTHER'S MAIDEN NAME First <b>Catherine</b> Middle <b>H</b> Last <b>Archibald</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>683098214</b>		17. INFORMANT Address <b>Isabella Jamieson 7108 Panopama Dr.</b>					
18. CAUSE OF DEATH Enter on y one cause per ne for a b, and c.											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Obstructive Vascular Disease</b>											
DUE TO OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis - Brain</b>											
DUE TO OR AS A CONSEQUENCE OF (c) <b>?</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <b>Diabetes Mellitus</b>											
9a. DATE OF OPERATION				9b. INDICATION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year <b>9</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>5-6-68</b> to <b>8-22-68</b> that (I) (we) last saw the deceased alive on <b>8-22-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I, (we) (did) (d) not) view the body after death											
22b. SIGNATURE <b>Jack Schumacher MD.</b>				DEGREE <b>MD.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8-23-68</b>			
22d. PHYSICIAN'S NAME Type <b>Jack Schumacher MD.</b>				22e. ADDRESS <b>105 Russell Ave. Gaithersburg, Maryland</b>							
23a. BURIAL/CREMATION <b>Cremation</b>		23b. DATE <b>August 26, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION City or Town County State <b>Suitland Prince Georges Md.</b>			
24. FUNERAL DIRECTOR <b>Tyson Wheeler F. H.</b>				ADDRESS <b>1331 Rockville Pk. Rockville, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>W. Charles Judge</b>	



# FIR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-8, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11743

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

75.

DECEASED NAME (Type or Print)		First	Middle	Last	DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
Mary Sabat				Jastrowski	Month	Day	Year	8	22	68
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE in years last birthday	7 IF UNDER 14 YEARS MONTHS	8 IF UNDER 14 YEARS DAYS	9 IF UNDER 14 YEARS HOURS	10 IF UNDER 14 YEARS MIN	2c DATE PROCLAIMED DEAD Month		2d HOUR
Female	White	12/18/01	66	XX				8		22
7a BIRTHPLACE State or foreign country		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Poland		USA				Montgomery				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12c USAL OCCUPATION (Kind of work done during most of working life, e.g., retired)		12b KIND OF BUSINESS OR INDUSTRY				
Silver Spring		Holy Cross Hospital		factory worker		factory				
3a USAL RESIDENCE (Where deceased lived 1 year or more at time of death or residence before admission) STATE		13b COUNTY		3c CITY OR TOWN		3d INSIDE CITY OR TOWN		13e STREET AND NUMBER		
Maryland		Montgomery		Sil. Sprg.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1400 Fenwick Lane Sil. Sprg.		
14 FATHER'S NAME		First	Middle	Last	5 MOTHER'S M.A.D.E.N. NAME		First	Middle	Last	
Sabat				?						?
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes, give war or dates of service)		17 INFORMANT		ADDRESS				
none		097-20-9995		son, <del>James</del> Hank		815 Thayer Ave. Sil. Spr. Md.				
B CAUSE OF DEATH (Enter only one cause per line. (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4129</u> <u>Acute Coronary Insufficiency</u>										
Conditions, if any, which gave rise to immediate cause, or, stating the underlying cause } (b) <u>Coronary Artery Heart Disease</u>										
(c) <u>lost</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>42</u>										
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month Day Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 8,				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		State
22a I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		
ACTUAL SIGNATURE <u>Belden R. Keap</u>				EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		ADDRESS <u>1 Prince Georges Co., Md.</u>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION City or Town		County		State
Cremation		August 23, 1968		Fort Lincoln Crematory		Prince Georges Co., Md.				
24 FUNERAL DIRECTOR (Name and address)				25a REL. BY REG. STRA		25b REG. NO.				
Warner C. Pumphrey, Inc. Silver Spring, Md.				DATE AUG 28 1968		JUDGE				



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 1B. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

11749

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

756

DECEASED NAME Type or Print: <b>DONNA</b>		First: <b>G.</b>		Middle: <b>JENKINS</b>		Last: <b>JENKINS</b>		2a DATE KNOWN OF DEATH: <input checked="" type="checkbox"/> EST <input type="checkbox"/> MATED <input type="checkbox"/> <b>AUG 29 9 68</b>		2b HOUR: <b>6:00</b>		
3 SEX: <b>FEMALE</b>	4 RACE: <b>CAUC.</b>	5 DATE OF BIRTH: <b>13 MARCH 54</b>	6 AGE in years last birthday: <b>14</b> YRS	7a MONTH: <b>MON</b>	7b YEAR: <b>54</b>	7c HOURS: <b>6</b>	7d MIN: <b>00</b>	2c DATE PRONOUNCED DEAD: <b>AUG 29 9 68</b>	2d HOUR: <b>6:00</b>			
7a BIRTHPLACE State or foreign country: <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY?: <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH: <b>MONTGOMERY</b>			10a			
10 CITY OR TOWN OF DEATH: <b>BETHESDA</b>		NAME OF HOSPITAL OR INSTITUTION (give street address): <b>NAVAL HOSPITAL</b>				12a SOCIAL OCCUPATION (Kind of work done during most of working life even if retired): <b>NA</b>			12b KIND OF BUSINESS OR INDUSTRY: <b>STUDENT</b>			
13a U.S.A. RESIDENCE (Where deceased lived + institution on Res. date before admission): <b>VA.</b>				13b COUNTY: <b>NOT KNOWN</b>		13c CITY OR TOWN: <b>KING GEORGE</b>		13d YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER: <b>ROUTE 2, BOX 303</b>		
14 FATHER'S NAME: <b>DARYL</b>		First: <b>MERT A</b>		Middle: <b>JENKINS</b>		15 MOTHER'S MAIDEN NAME: <b>LUCY NALLS</b>		First: <b>JENKINS</b>		Last: <b>JENKINS</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): <b>NA</b>		16b SOCIAL SECURITY NO: <b>NONE</b>		17 INFORMANT: <b>ROUTE 2, BOX 303, KING GEORGE, VA.</b>				ADDRESS: <b>ROUTE 2, BOX 303, KING GEORGE, VA.</b>				
8 CAUSE OF DEATH (Enter only one cause per line for a, b, and c, PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE, a) <b>Subdural hemorrhage and cerebral contusions</b>										APPROXIMATE INTERVAL BETWEEN DEATH AND PATH		
b) <b>Massive skull fracture</b>												
c) <b>Alleged vehicle accident</b>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1												
19a DATE OF OPERATION: <b>8/21</b>				19b CONDITION FOR WHICH OPERATION WAS PERFORMED: <b>NONE</b>				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTR. BUTING CAUSE OF DEATH: <b>3:15 PM AUG 29 68</b>				21b TIME OF INJURY Month Day Year: <b>3:15 PM AUG 29 68</b>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 8): <b>Passenger in school bus hit and struck by truck</b>				
22a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22b PLACE OF INJURY At home, farm, street, factory, office building, etc.: <b>SCHOOL BUS</b>				22c LOCATION Street or R.F.D. No. City or Town: <b>ROUTE 301, SOUTH OF POTOMAC RIVER VA.</b>				
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accidents <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE: <b>John G. Ball</b>		EXAMINER'S NAME Type: <b>JOHN G. BALL MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED: <b>29 AUG 68</b>		
23a BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> Specify: <b>BURIAL</b>		23b DATE: <b>9-2-68</b>		23c NAME OF CEMETERY OR CREMATORY: <b>SUNBURY CEMETERY</b>		23d LOCATION City or Town, County, State: <b>PRINCETON, WEST VIRGINIA</b>						
24a NAME OF FUNERAL HOME: <b>WILLIAM H. HUMPHREY, 7557 WISCONSIN AVE, BETH. MD.</b>						25a REC'D BY REGISTRAR: <b>SEP 10 1968</b>		25b REGISTRAR'S SIGNATURE: <b>Charles Judge</b>				





TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the bur of transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15  
30M REV

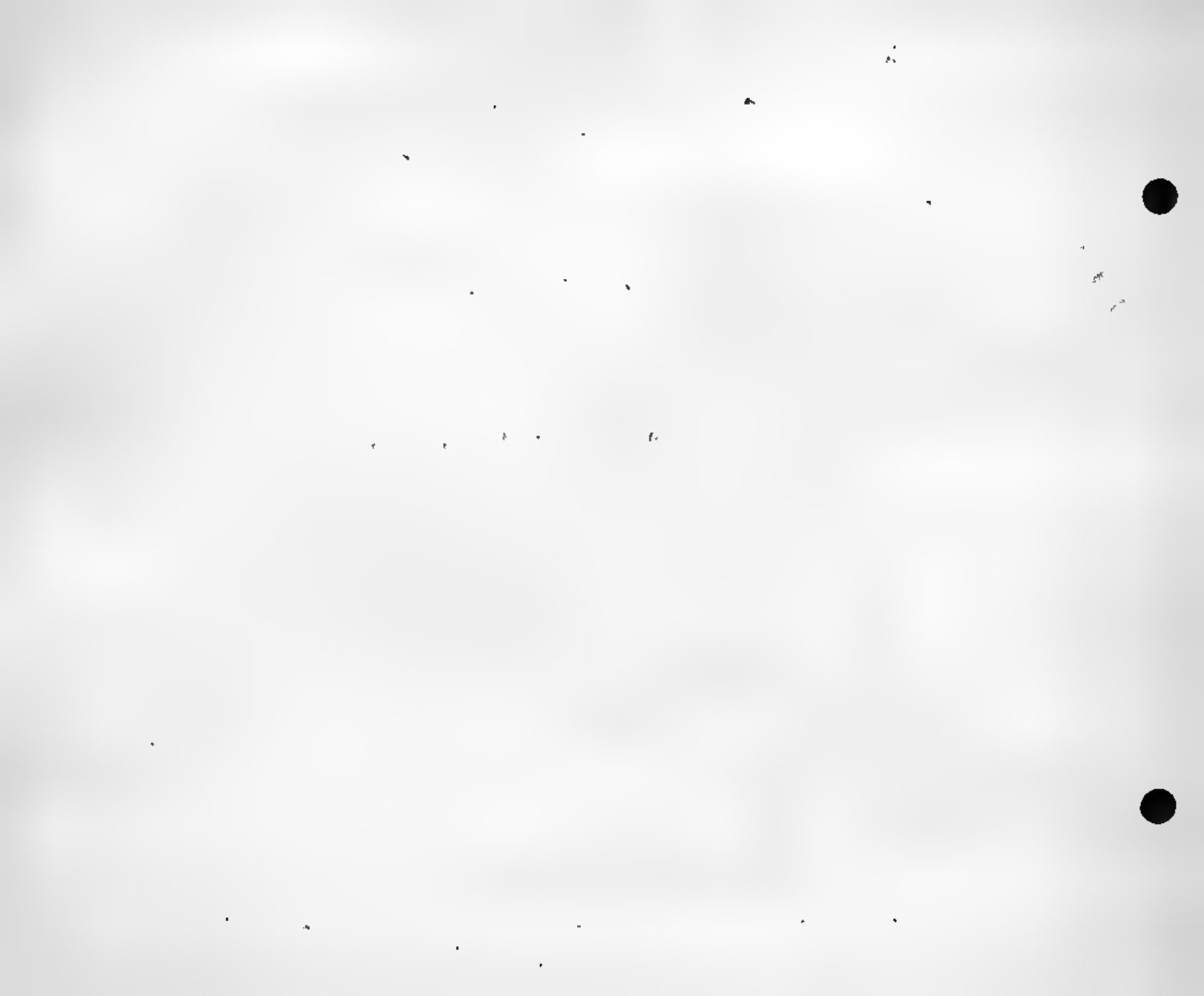
11750

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

DECEASED-NAME (Type or print) <b>Robert S Johnson</b>			2a. DATE OF DEATH Month <b>Aug</b> Day <b>31</b> Year <b>1968</b>			2b. HOUR <b>7A</b> M	
3 SEX <b>Male</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH <b>1/23/10</b>		6 AGE in years (last birthday) <b>58</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b> Md.	
10 CITY OR TOWN OF DEATH <b>Montgomery</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Suburban</b>		2a. USUAL OCCUPATION, Kind of work done during most of work ing life even if retired;		12b. KIND OF BUSINESS OR INDUSTRY	
3a. USUAL RESIDENCE Where deceased lived (admission) STATE <b>Md.</b>		3b. COUNTY <b>Mont</b>		3c. CITY OR TOWN <b>Rockville</b>		3d. INSIDE CITY (INMAY) YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>Robert</b> Middle <b>Martin</b> Last <b>Johnson</b>		15. MOTHER'S MAIDEN NAME First <b>Lucy</b> Middle <b>Locke</b> Last <b>Johnson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <b>unknown</b> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO	
17 INFORMANT		Address		18 CAUSE OF DEATH (Enter only one cause per line for a, (b), and c.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE, (a) <b>Bronchogenic carcinoma, left, with metastases</b>		1621		DUE TO, OR AS A CONSEQUENCE OF		<b>2 years</b>	
Conditions, if any, which gave rise to immediate cause, (a), stating the underlying cause		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (either notify med. ex. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 (Item 18))			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/26</b> 19 <b>62</b> to <b>8/31</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>8/30</b> 19 <b>62</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death							
22b. SIGNATURE <b>Sidney J. Cohen</b> M.D. DEGREE		22c. ADDRESS <b>50 W. Edmonstone Dr., Rockville, Md.</b>		22d. DATE SIGNED <b>8/31/68</b>		22e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
23a. B.R.A. CREMATION REMOVAL SPECIAL <b>9-6-68</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park Cem</b>		23d. LOCATION City or Town, (County) State <b>Rockville Montgomery Md.</b>	
24. FUNERAL DIRECTOR <b>Sam R. Jordan</b>		ADDRESS <b>Rockville</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1968</b>		25b. REGISTRAR'S SIGNATURE	

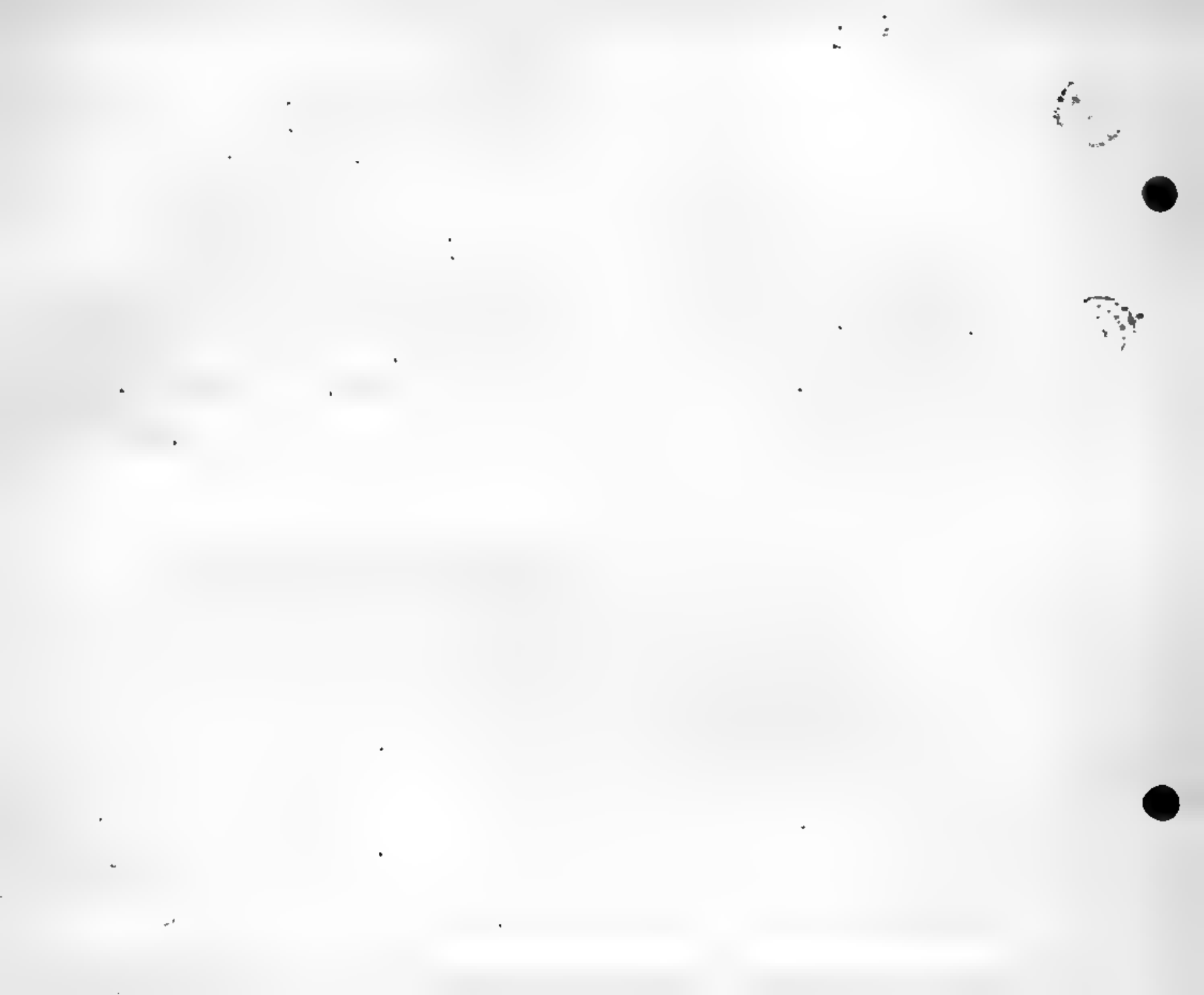
MEDICAL CERTIFICATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11751												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												758	
1 DECEASED-NAME (Type or print) First Middle Last Frieda, W. Johnston												2a. DATE OF DEATH Month Day Year Aug. 9 1968												2b. HOUR 12:48 AM	
3 SEX Female				4 RACE White				5. DATE OF BIRTH MAR. 25, 1922				6 AGE in years (last birthday) 46 YRS				7 UNDER YEAR MONTHS DAYS HOURS				8 UNDER 24 HRS HOURS					
7a BIRTHPLACE (State or foreign country) Penn.				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH Montgomery Md													
10. CITY OR TOWN OF DEATH Silver Spring				11 NAME OF HOSPITAL OR INSTITUTION (not in hospital give street address) Holy Cross Hosp.				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Housewife				12b KIND OF BUSINESS OR INDUSTRY													
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland - Prince Georges County				13b CITY OR TOWN Silver Spring				13c INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d STREET AND NUMBER 6505-Handover Rd.													
4 FATHER'S NAME First Middle Last LOUIS WEISENFELD				15 MOTHER'S MAIDEN NAME First Middle Last MINNIE SCHWARTZBERG																					
6a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				16b SOCIAL SECURITY NO UNKNOWN				17 INFORMANT JOSEPH JOHNSTON				Address (Same as 8)													
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cocaine of Brestinta quididitator 3yr</u> 174X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 170X																									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)																	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from January, 1962 to August, 1968 that (I) (we) last saw the deceased alive on August 8, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																									
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED Aug 9, 1968																	
22d. PHYSICIAN'S NAME (Type) BLAINE H. ELG				22e. ADDRESS 9801 Denzian and Silver Spring Rd																					
23a. BURIAL, CREMATION, OR OTHER DISPOSITION BURIAL				23b. DATE 8/12/68				23c. NAME OF CEMETERY OR CREMATORY NATL. MEM. PARK				23d. LOCATION (City or Town) (County) (State) FALLS CHURCH VA													
24. FUNERAL DIRECTOR Gardner & Co. Funeral Home				ADDRESS 217 9th St N.E. Wash D.C.				25a. REC'D BY REGISTRAR DATE AUG 12 1968				25b. REGISTRAR'S SIGNATURE Charles Judge													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First F. Middle HOYT Last JONES						2a DATE OF DEATH 8 Month 9 Day 68 Year			2b HOUR 7 A M		
3 SEX Male		4 RACE Cauc.		5 DATE OF BIRTH Aug. 26, 1904		6 AGE (in years last birthday) 63 YRS.		7 IF UNDER YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HRS. MIN.	
7a BIRTHPLACE (State or foreign country) Illinois		7b CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md					
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 10401 Grosvenor Place				12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) Retired			12b KIND OF BUSINESS OR INDUSTRY FHA		
3a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 10401 Grosvenor Place			
14 FATHER'S NAME First Middle Last Charles W. Jones				15 MOTHER'S MAIDEN NAME First Middle Last Grace Hoyt							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 359-14-5184		17 INFORMANT Wife		Address Same as Item 13.					
17b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> 4120 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ESSENTIAL HYPERTENSION</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home - farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from 1953 to 8/9 1968, that (I) (we) last saw the deceased alive on 8/9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (d) (not) view the body after death											
22b. SIGNATURE Richard H. Pollen MD		22c. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN		22d. ADDRESS 10400 CONNECTICUT AVE, KEESINGTON, Md		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED 8/9/68			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-12-68		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland					
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE AUG 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carton paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event not in less than 24 hours after death.

11753

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 13 Film - 100-100000-100000

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)

First Middle Last

2a. DATE OF DEATH

Month Day Year

2b. HOUR

3 SEX

4 RACE

5. DATE OF BIRTH

6 AGE in years (last birthday)

7a. BIRTHPLACE (State or foreign country)

7b. CITIZEN OF WHAT COUNTRY?

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 COUNTY OF DEATH

10 CITY OR TOWN OF DEATH

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)

12a. USLA OCCUPATION Kind of work done during most of working life even if retired

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS YES ☐ NO ☐

13e. STREET AND NUMBER

14 FATHER'S NAME

15 MOTHER'S MAIDEN NAME

16a. DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.

17. INFORMANT

Address

8 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.

21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 8b)

22a. I certify that (I) (this hospital) attended the deceased from Aug 8, 1968 to Aug 29, 1968, that (I) (we) last saw the deceased alive on Aug 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death

22b. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

22e. DATE SIGNED

23a. BURIAL, CREMATION, CREMATION

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation or entombment, and in any event, within 72 hours after death.

VR A 5/64  
30M REV 6/58

11754

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

61

DECEASED NAME (Type or print) <i>Thaddeus Melvin Jones</i>		2a DATE OF DEATH Month <i>8</i> Day <i>16</i> Year <i>68</i>	2b HOUR <i>5:20 PM</i>
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>8/20/1882</i>	6 AGE (In years last birthday) <i>85</i> YRS
7a BIRTHPLACE (State or foreign country) <i>So North Va</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>
10 CITY OR TOWN OF DEATH <i>Wheaton</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>University Nursing Home</i>	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Contractor</i>	12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived) admission STATE <i>Md</i>	13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Silver Spring</i>	3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
4 FATHER'S NAME <i>Thaddeus Melvin Jones</i>	5 MOTHER'S MAIDEN NAME <i>Mary Cordelia Brinkley</i>	3e STREET AND NUMBER <i>8613 Piney Branch Rd.</i>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes, no, or unknown	16b SOCIAL SECURITY NO <i>518-09-4599</i>	17 INFORMANT <i>Wife</i>	Address <i>Same</i>
8 CAUSE OF DEATH Enter only one cause per line for a, b, and c. PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>general debility</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of prostate</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>			APPROXIMATE INTERVAL BETWEEN ONSET AND CLINICAL DEATH <i>2 mo</i> <i>2 yrs</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic pyelonephritis</i>			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either not by medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>68</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B)	
21d NATURE OF INJURY While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No. City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from <i>7-15, 1968</i> to <i>8-16, 1968</i> , that (I) (we) lost saw the deceased alive on <i>8-13, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death			
22b SIGNATURE <i>R. H. Sengstack M.D.</i>	22c PHYSICIAN'S NAME (Type) <i>G.F. Sengstack</i>	22d ADDRESS <i>9241 Columbia Blvd. Silver Spring, Md.</i>	22e DATE SIGNED <i>8-16-68</i>
23a BIRTH DATE <i>8/20/1882</i>	23b DATE <i>8/20/68</i>	23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	23d LOCATION (City or Town, County) State <i>Suitland, Md.</i>
24 FUNERAL DIRECTOR <i>The H. Hines Co.</i>	24a ADDRESS <i>2901 14th ST. NW.</i>	25a REC'D BY REGISTRAR <i>AUG 19 1968</i>	25b REGISTRAR'S SIGNATURE <i>J. M. Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

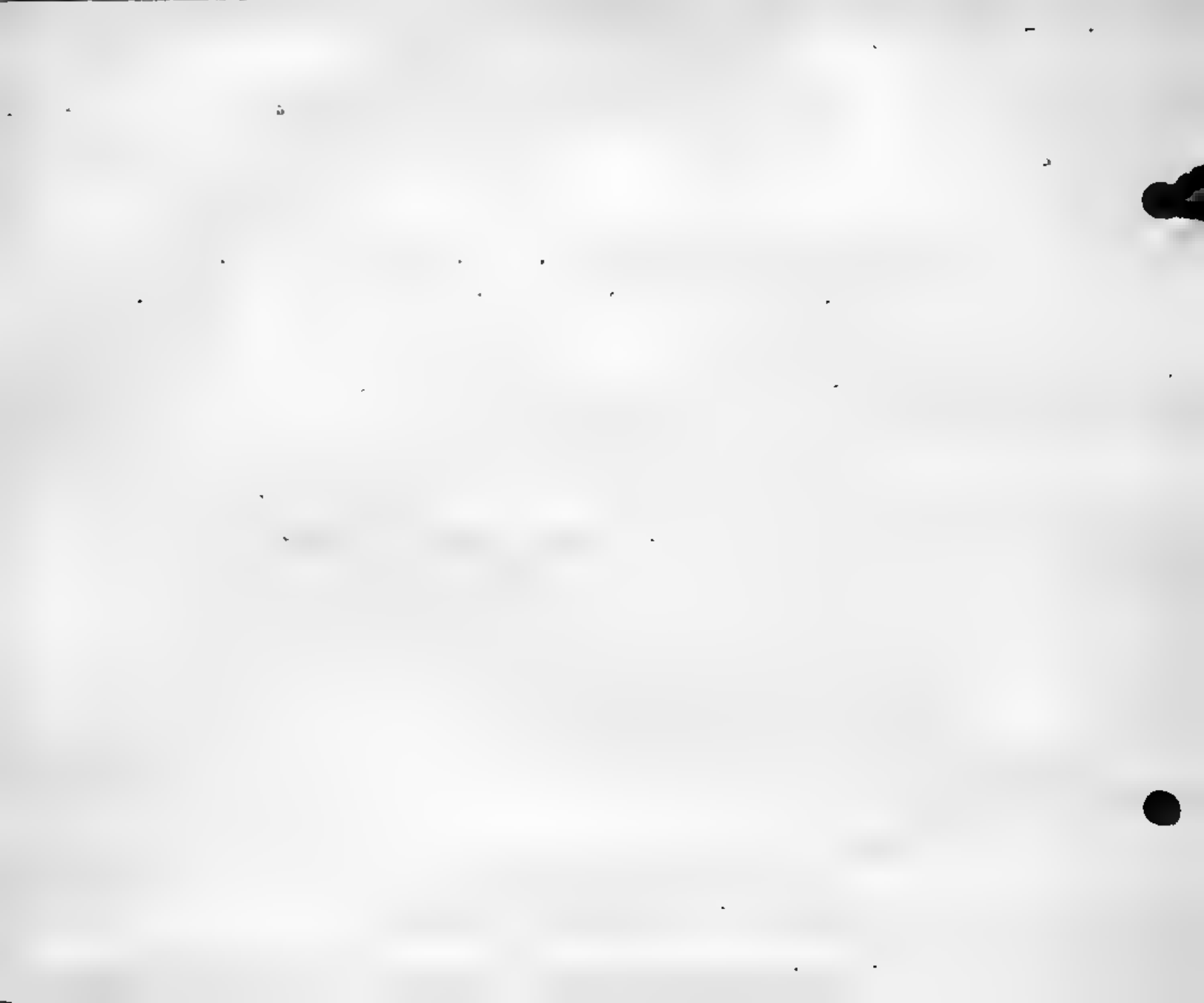
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

11753

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

11762

1 DECEASED NAME (Type or print) First Middle Last <b>JERRY JOHN KALIVAS</b>			2a. DATE OF DEATH Month Day Year <b>August 29, 1968</b>		2b. HOUR <b>8:25p.</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>8-23-97</b>		6 AGE in years (last birthday) <b>71</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Greece</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San. &amp; Hosp.</b>		12a. USAL OCCUPATION (Kind of work done during most of work ng. be even if retired) <b>Restaurant Mgr.</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Montgomery</b>	3c. CITY OR TOWN <b>Silver Spring</b>	3d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	3e. STREET AND NUMBER <b>12 Hamilton Ave.</b>	
14. FATHER'S NAME First Middle Last <b>John Jerry Kalivas</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Dimitra KOLIVAS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>156-07 8293</b>		17 INFORMANT Address <b>Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis C-V. Disease</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b> Approximate interval between onset and death <b>about 5-10 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>42</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If other, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home - ARM. STREET FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 2, 1942, to Aug 13, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Aug 13, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death					
22b. SIGNATURE <b>Benjamin Isaacson</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/30/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>BENJAMIN ISAACSON</b>		22e. ADDRESS <b>WASH SANT-HOSPIT TAKOMA PK MD</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>	23b. DATE <b>8-30-68</b>	23c. NAME OF CEMETERY OR CREMA ORY <b>BALTIMORE NATL CEM</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers CO</b>		ADDRESS <b>1400 Chapel St</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 3 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 ☒ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove corobac paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

11758

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11763

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR
Stanley, Karmazin					August 29, 1968		5:00 PM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
male	White	March 27, 1898		70 YRS.			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Ukraine	USA?			Montgomery		Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		2a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		2b KIND OF BUSINESS OR INDUSTRY	
Silver Spring, Md.		Holy Cross Hosp		Government worker Retired			
3a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		3c CITY OR TOWN		3d INSIDE CITY, WARD	
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3e STREET AND NUMBER		8811-Colesville Rd.					
14 FATHER'S NAME		First Middle Last		5 MOTHER'S MAIDEN NAME		First Middle Last	
CHAIM		KARMAZIN		GITTEL		???	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		7 INFORMANT		Address	
No		577-34-7085		Miriam Karmazin		Same as 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIOCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 HRS 5 YRS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>TAUL</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
FOR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year					
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work							
22a I certify that (I) (this hospital) attended the deceased from <u>1965</u> 19 to <u>Aug-29</u> 19 <u>68</u> that (i) (we) last saw the deceased alive on <u>Aug-29</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d a) (did not) view the body after death							
22b SIGNATURE				22c DATE SIGNED			
SAUL ZUKERMAN M.D.				8-29-68			
22d PHYSICIAN'S NAME (Type)		22e ADDRESS					
SAUL ZUKERMAN, M.D.		5410 CONNECTICUT AVE N.Y.					
23a BURIAL, CREMATION, REMOVAL, SPEAKY		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		8-30-68		D.C. Lodge Cemetery		Washington, DC	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Goldberg Funeral Home		WASH DC		SEP 3 1968		Karmazin	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form-254. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. See pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal; and in any event within 72 hours after death.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type or Print) First Middle Last <b>Mary Elizabeth Keston</b>			2a DATE KNOWN OF DEATH Month Day Year <b>8-20 1968</b>			2b HOUR OF DEATH Hour Minute <b>2:25 PM</b>		
3 SEX <b>F</b>	4 RACE <b>W</b>	5 DATE OF BIRTH <b>2-8-1888</b>	6 AGE In years In months In days <b>80 YRS</b>	7a UNDER 1 YEAR Month Week Day <b>10 1 1</b>	7b UNDER 24 HRS Hours Minute <b>10 1</b>	2c DATE PRONOUNCED DEAD Month Day Year <b>8-20 1968</b>		
7a BIRTHPLACE State or foreign (country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>		
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>		NAME OF HOSPITAL OR INSTITUTION (not in hospital give street address) <b>Washington San &amp; Hosp</b>				12a USUAL OCCUPATION (kind of work done during most of working life even if retired) <b>Housewife</b>		2b KIND OF BUSINESS OR INDUSTRY <b>Home</b>
3a USUAL RESIDENCE (Where deceased lived, + no location. Residence before admission STATE <b>Md.</b>			3b COUNTY <b>Mont.</b>	3c CITY OR TOWN <b>Sil. Spr.</b>	3d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3e STREET AND NUMBER <b>1021 University Blvd., E</b>		
4 FATHER'S NAME First Middle Last <b>Samuel E Ward</b>				5 MOTHER'S M maiden name First Middle Last <b>Harriet Rebecca</b>				
6a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>			6b SOCIAL SECURITY NO <b>214 12 7527A</b>		17 INFORMANT ADDRESS <b>Dr. James R. Keaton Loma Linda California</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a), <b>Acute pneumococcal meningitis</b> <b>3201</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>3401</b>								
19a DATE OF OPERATION			9b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		2b TIME OF INJURY Month Day Year Hour A.M. P.M. <b>19</b>		2c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 8)			2d LOCATION Street or RFD No City or Town County State	
2e INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		2f PLACE OF INJURY At home, farm, street, factory, office building, etc.)						
22a I certify that took charge of the remains described above, and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Belden R. Keaton</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME Type <b>BELDEN R. KEATON</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>Aug. 20, 1968</b>		
23a BURIAL OR CREMATION REMOVAL Specify <b>Burial</b>		23b DATE <b>Aug 23, 1968</b>		23c NAME OF CEMETERY <b>Arlington National</b>		23d LOCATION City or Town County State <b>Arlington Virginia</b>		
24 FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>				25a RECORD BY REGISTRAR <b>Aug 26 1968</b>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

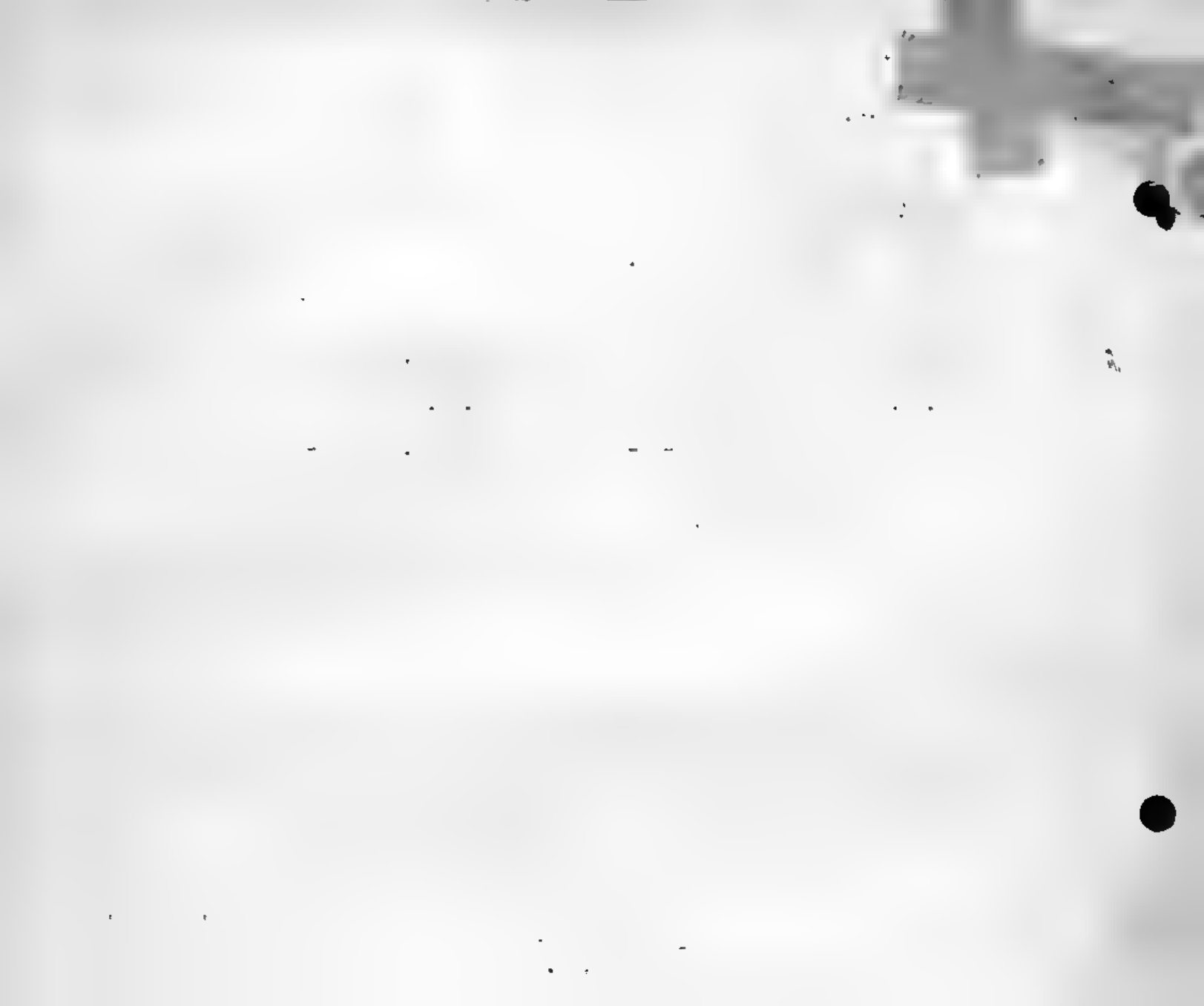
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11758  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7118 Glenbrook Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>7118 Glenbrook Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HUGH V. KEISER</b>		4. DATE OF DEATH <b>Aug. 16 1968</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/6/89</b>
9. AGE (in years last birthday) <b>79</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Lonoke, Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Wm. S. Keiser</b>		14. MOTHER'S MAIDEN NAME <b>L. A. Jenkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-03-4462</b>	
17. INFORMANT <b>Caroline F. Keiser- Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertension bone marrow</b> <b>myeloid marked leukemoid</b> <b>reaction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Permeic acid anemia</b> (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 28 1965</b> to <b>Aug 15 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 15 1968</b> , and that death occurred at <b>1 A M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>C P Ryland</b>		22b. DATE SIGNED <b>8-16-68</b>	
22c. PHYSICIAN'S NAME (Type) <b>C P RYLAND</b>		22d. ADDRESS <b>4400-49th St. NW Washington DC</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/19/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	23d. LOCATION (City, town or county) (State) <b>Prince George, County, Md.</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 19 1968</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

25a. REC'D BY REGISTRAR **AUG 19 1968**

25b. REGISTRAR'S SIGNATURE

DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript. Then please remove carbon papers, pages 1 and 2, and return them to the State Department of Health. The death certificate should be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

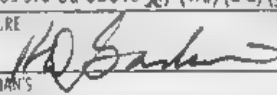
1

11759

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1968

# CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <b>John L. KENDIG</b>			2a DATE OF DEATH Month Day Year <b>August 14, 1968</b>		2b HOUR <b>10:15P</b>
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH <b>September 15, 1882</b>	6 AGE in years (lost birthday) <b>85</b> YRS	7 UNDER YEAR MONTHS DAY <b>11 14</b>	8 UNDER 24 HRS HOURS MIN. <b>10 15</b>
7a BIRTHPLACE (State or foreign country) <b>Ohio</b>	7b CIT ZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Montgomery</b> Md		
10 CITY OR TOWN OF DEATH <b>Bethesda</b>	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Naval Hospital</b>	12a US JAIL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>USN</b>	2b K. NO OF BUSINESS OR INDUSTRY		
13a SOCIAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <b>Virginia</b>	13b COUNTY <b>Arlington</b>	13c CITY OR TOWN <b>Arlington</b>	13d MIDDLE CITY (ZIP) <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	3a STREET AND NUMBER <b>700 North Wayne Street</b>	
14 FATHER'S NAME First Middle Last <b>John L. Kendig</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Louise Jane Bowers</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or date of service. <b>yes</b>		16b SOCIAL SECURITY NO		17 INFORMANT <b>Arlington, Va. 22201</b> <b>Mrs. Mary E. Kendig, 700 N. Wayne Street,</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer of lung with metastases</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f LOCATION Street or RFD No. City or Town County State	
22a I certify that (A) (this hospital) attended the deceased from <b>July 22, 1968</b> to <b>August 14, 1968</b> , that (A) (we) lost saw the deceased alive on <b>August 14, 1968</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (a) (b) (c) view the body after death					
22b SIGNATURE 		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <b>15 Aug '68</b>	
22d PHYSICIAN'S NAME (Type) <b>R. D. GASKINS</b>		22e ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE <b>Aug 19, 1968</b>	23c NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24 FUNERAL DIRECTOR <b>Ives Funeral Home</b>		ADDRESS <b>2847 Wilson Blvd., Arlington, Va.</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b> DATE <b>AUG 19 1968</b>	
				25b REGISTRAR'S SIGNATURE	

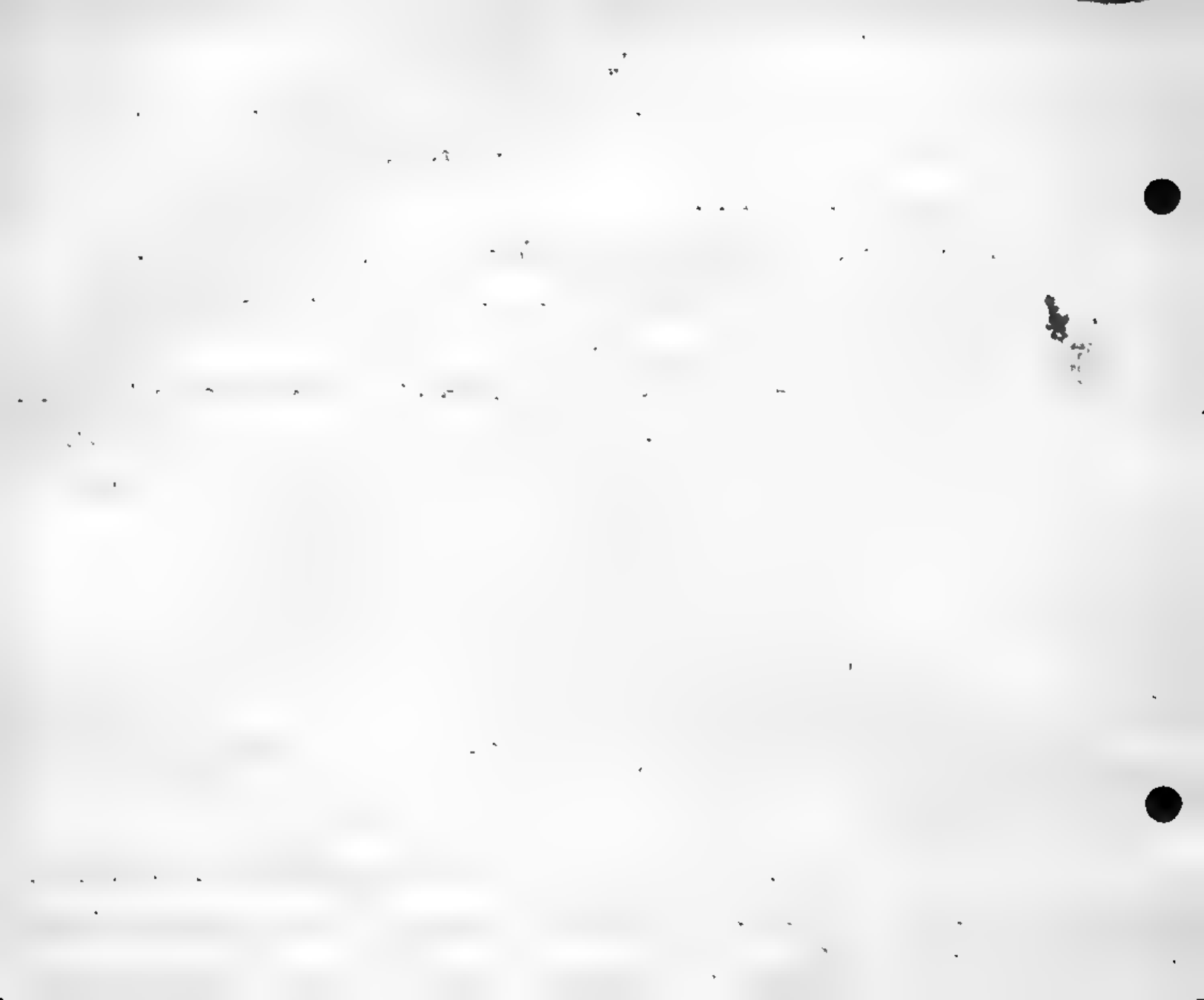


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A 5  
30M REV 1-68

11760										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11761																																							
1 DECEASED NAME (Type or print) First Middle Last										2a DATE OF DEATH Month Day Year										2b HOUR																																							
Mary Kent										August 15 1968										1:00 P.M.																																							
3 SEX Female										4 RACE White										5 DATE OF BIRTH October 28, 1879/										6 AGE (In years lost birthday) 88 YRS.										7 IF UNDER 1 YEAR MONTHS DAYS										8 IF UNDER 1 YEAR HOURS MIN									
7a BIRTHPLACE (State or foreign country) Orleans, Mass.										7b CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH Montgomery/										Md.																			
10 CITY OR TOWN OF DEATH Silver Spring,										NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) 2904 New Castle Avenue										12a LSMA, OCCUPATION (Kind of work done during most of working life even if retired.)										12b KIND OF BUSINESS OR INDUSTRY own home																													
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Md.										13b COUNTY Montgomery										13c CITY OR TOWN Silver Spr.										13d STREET AND NUMBER 2904 New Castle Avenue																													
4 FATHER'S NAME First Middle Last Rollin Lindsay										15 MOTHER'S MAIDEN NAME First Middle Last Susan Snow										16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (No, or unknown) No										16b SOCIAL SECURITY NO None										17 INFORMANT Address Mrs. James Guida 2904 New Castle Avenue S.S.																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cerebral thrombosis										2 weeks																																																	
DUE TO, OR AS A CONSEQUENCE OF CEREBRAL ATHEROSCLEROSIS										2 YEARS																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>										21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.										21f LOCATION Street or R.F.D. No. City or Town County State																																							
22a I certify that (I) (th's hospital) attended the deceased from Feb. 5 1968 to August 15 1968, that (I) (we) last saw the deceased alive on August 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death										22b SIGNATURE James A. Roberts M.D.										22c DATE SIGNED 8/15/68																																							
22d PHYSICIAN'S NAME (Type) James A. Roberts										22e ADDRESS 8907 Georgia Avenue Silver Spring, Md.																																																	
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation										23b DATE Aug. 15, 1968										23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory										23d LOCATION (City or Town) (County) (State) Prince Georges! Maryland																													
24 FUNERAL DIRECTOR C. Glen Carter										25a REC'D BY REGISTRAR Warner E. Pumphrey Inc. 8434 Georgia Ave. S.S.										25b REGISTRAR'S SIGNATURE J. Charles J. J. J.																																							



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11762

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1768

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Warren</i>		Middle <i>Kilby</i>		Last <i>Sk</i>		2a DATE OF DEATH 8 Month <i>25</i> Day <i>68</i> Year		2b HOUR <i>4:30</i> AM	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>3-4-17</i>		6 AGE (in years last birthday) <i>51</i> YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign, country) <i>Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> MD			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION Kind of work done during most of work night, even if retired <i>Depot Shop - Mgmt. Co.</i>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Mont. Germantown</i>		3. CITY OR TOWN <i>R.D. #1</i>		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER	
14 FATHER'S NAME First <i>Lewis</i> Middle <i>Kilby</i> Last <i>Sk</i>		15 MOTHER'S NAME First <i>Sarah</i> Middle <i>Carizzo</i> Last <i>Sk</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i>		16b SOCIAL SECURITY NO <i>218-091081</i>		7 INFORMANT <i>Wife - Rosalyn</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of head of Pancreas</i> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <i>3rd</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION <i>8/17/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>carc. head of pancreas</i>		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year <i>9</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 of Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/12</i> 19 <i>68</i> to <i>8/25</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>8/24</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Frederick Y. Donn, M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. D. REL. TOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <i>8/25/68</i>			
22d. PHYSICIAN'S NAME (Type or print) <i>FREDERICK Y. DONN</i>		22e ADDRESS <i>10400 Connecticut Ave. Bethesda, Md.</i>							
23a BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>8-28-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Park Lawn</i>		23d LOCATION (City or Town) (County) State <i>Rockville, Mont. Md.</i>			
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>				Gathersburg, Md.		25a. REGD. BY REGISTRAR <i>James Judge</i>		25b. REGISTERED COUNTY <i>Montgomery</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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11762		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				769	
Item # 162, Film G. 23 8/16/68 km							
1. DECEASED NAME (Type or print) <b>Bryan Zinn Kile</b>			2a. DATE OF DEATH Month <b>Aug.</b> Day <b>7,</b> Year <b>1968</b>			2b. HOUR <b>P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 3, 1896</b>		6. AGE (In years last birthday) <b>71</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Laytonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7301 Warfield Road</b>		12a. U.S.A. OCCUPATION Kind of work done during most of working life even if retired <b>Management - Analyst</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Aviation Agency</b>	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Laytonsville</b>		13d. STREET AND NUMBER <b>7301 Warfield Road</b>	
14. FATHER'S NAME First Middle Last <b>Morris Kile</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Marie Zinn</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give major or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-38-5577</b>		17. INFORMANT <b>Mrs. Bryan Z. Kile</b>		17a. ADDRESS <b>7301 Warfield Road Laytonsville, Md.</b>	
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intra-Cranial Hemorrhage</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>Metastatic Adeno. 6-8 months</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>Carcinoma - Secondary</b> CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause (b), PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Carcinoma - St. Stem Bronchi (Primary)</b>							
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, not a medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
22a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1958</b> 19 to <b>1968</b> that (I) (we) lost saw the deceased alive on <b>Aug. 7 - 68</b> and that (my) (our) opinion on death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <b>Jack Schumacker</b>		DEGREE <b>Jack Schumacker</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-8-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Jack Schumacker</b>		22e. ADDRESS <b>Gaithersburg Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Aug. 10 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville Md.</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 12 1968</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

site

11/11/70

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11763

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

DECEASED NAME (Type or print) <u>Marguerite</u>		First	Middle	Last	2a. DATE OF DEATH Month <u>Aug.</u> Day <u>5</u> Year <u>1968</u>		2b. HOLR. <u>6:30 PM</u>	
3 SEX <u>Female</u>	4 RACE <u>White</u>	5 DATE OF BIRTH <u>June 4, 1902</u>			6 AGE in years (last birthday) <u>66</u> YRS		7 MONTHS <u>2</u>	8 DAYS <u>1</u>
9a BIRTHPLACE State or foreign country <u>Maryland</u>		9b CITIZEN OF WHAT COUNTRY? <u>U S A</u>		9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u>		
10 CITY OR TOWN OF DEATH <u>Bethesda</u>		11 NAME OF HOSPITAL OR INSTITUTION, if not in hospital give street address <u>Suburban Hospital</u>		12a Usual OCCUPATION Kind of work done during last working period (if treated)		12b KIND OF BUSINESS OR INDUSTRY <u>Private</u>		
13a Usual RESIDENCE, Where deceased lived if institution Residence before admission) STATE <u>Md.</u>		13b COUNTY <u>Mont Co</u>		13c CITY OR TOWN <u>Cherry Chase</u>		13d INSIDE PHONE NO. YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>117-17 Crafton St.</u>
4 FATHER'S NAME First <u>James</u> Middle <u>Edward</u> Last <u>Mitchell</u>		5 MOTHER'S MAIDEN NAME First <u>Margaret</u> Middle <u>Julia</u> Last <u>Wilson</u>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		6b SOCIAL SECURITY NO. <u>220-01-1623D</u>		17 INFORMANT <u>Suburban Hospital</u>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO OR AS A CONSEQUENCE OF (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Urinary Tract Infection Diabetes Mellitus</u>								
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (If home, farm, street, factory, or building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (the hospital) attended the deceased from <u>Aug 22</u> 1968, to <u>Aug 5</u> 1968, that (I) (we) last saw the deceased alive on <u>July 22</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death								
22b SIGNATURE <u>James J. Foster MD.</u>				22c DEGREE <u>MD</u>		22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e DATE SIGNED <u>Aug 5, 1968</u>
22f PHYSICIAN'S NAME (Type) <u>James J. Foster MD.</u>				22g ADDRESS <u>915 19th NW, Wash D.C.</u>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <u>8/9/68</u>		23c NAME OF CEMETERY OR CREMATORY <u>Arl. Nat'l Cemetery</u>		23d LOCATION (City or Town County, State) <u>Arl. Va.</u>		
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey 7557 Wise Ave. Bethesda Md.</u>				25a REC'D BY REGISTRAR DATE <u>AUG 8 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (10)  
JOM REV. 1-58

11764

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1171

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>First</u> <u>Middle</u> <u>Last</u> <u>William</u> <u>McGEE</u> <u>Kline</u>			2a. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1968</u>			2b. HOUR <u>7:55</u> AM	
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>5-3-04</u>		6. AGE in years last birthday <u>64</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Penn.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u>	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		12a. USUA. OCCUPATION (Kind of work done during past 12 months, even if retired) <u>engineer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Coe Const.</u>	
13a. USUA. RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda</u>		13d. STREET AND NUMBER <u>8010 Maple Ridge Road</u>	
14. FATHER'S NAME First <u>William</u> Middle <u>W.</u> Last <u>McGEE</u>		15. MOTHER'S MAIDEN NAME First <u>MARY</u> Middle <u>Anderson</u> Last <u>Anderson</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give date of service)		16b. SOCIAL SECURITY NO. <u>578-01-3908</u>		17. INFORMANT <u>Evelyn Kline - WIFE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hypertension</u> (b) <u>Brain aneurysm - Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Atherosclerosis</u> (c) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour <u>AM</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, ARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/23/68</u> to <u>8/23/68</u> that (I) (we) last saw the deceased alive on <u>8/23/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <u>W. T. Joyce</u>		22c. DATE SIGNED <u>8/23/68</u>		22d. ADDRESS <u>4977 Battery Lane, Bethesda, Md.</u>			
23a. BURIAL/CREMATION (Specify)		23b. DATE <u>8/26/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION City or Town (County) State <u>Rockville, Montg. Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

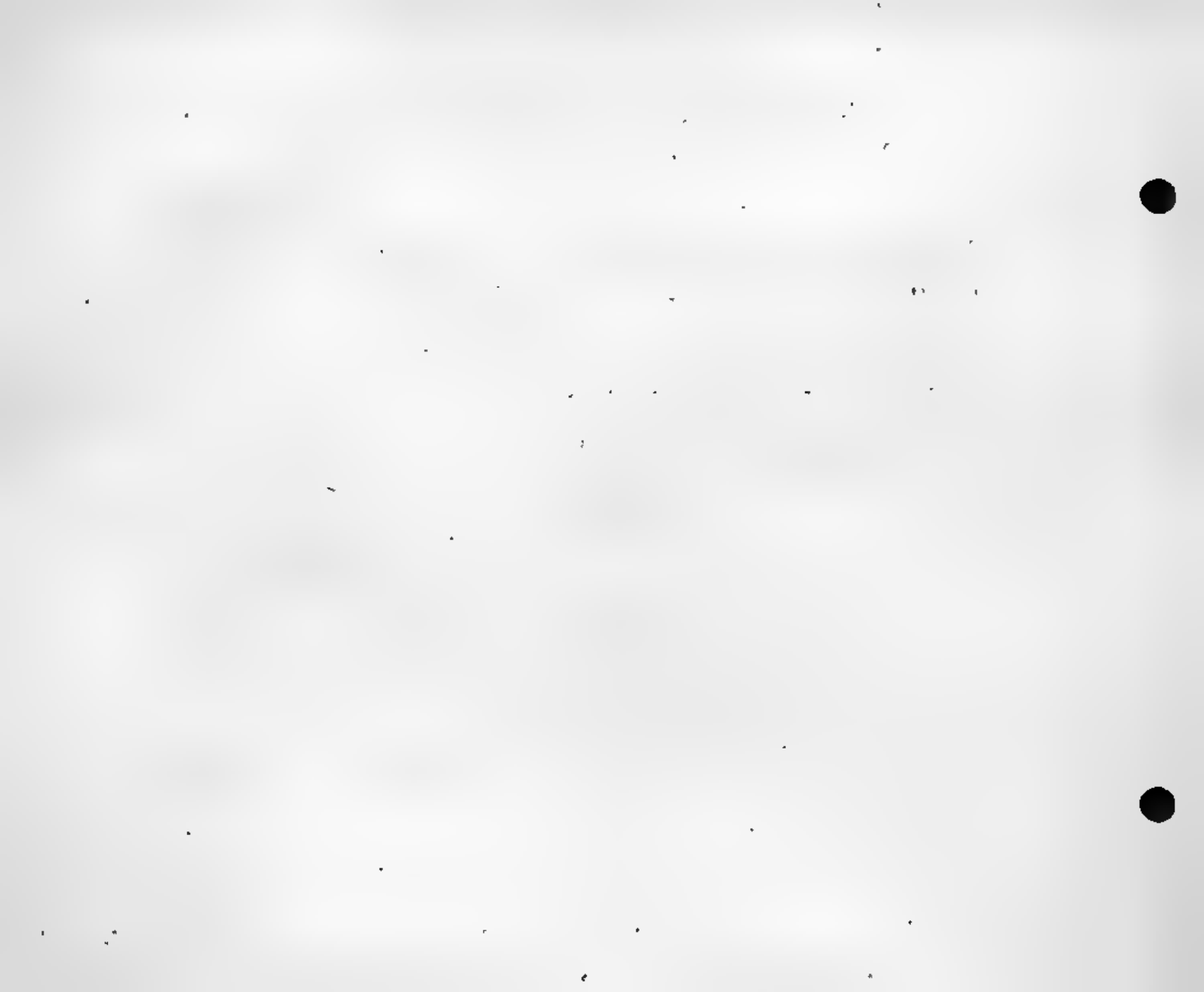
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11765

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

772

1. DECEASED NAME (Type or print) <b>Thomas M. Knapp</b>			2a. DATE OF DEATH Month <b>8</b> / Day <b>15</b> / Year <b>68</b>			2b. HOUR <b>7:15 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>6/6/05</b>		6. AGE, in years last birthday <b>63</b> YRS.		7. UNDER YEAR MONTHS <b>2</b> DAYS <b>9</b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Suburban Hospital</b>		2a. USIA. OCCUPAT ON (Kind of work done during most of working life even if retired) <b>Disabled</b>		2b. KIND OF BUSINESS OR INDUSTRY			
3a. USIA. RESIDENCE (Where deceased lived, if institution Residence before admission) <b>Maryland</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Bethesda</b>		3c. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4534 Avondale St.</b>	
4. FATHER'S NAME First Middle Last <b>Thomas Knapp</b>			5. MOTHER'S MAIDEN NAME First Middle Last <b>Katherine Murray</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown? <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>534-05-4145</b>		17. INFORMANT Address <b>Iris Irene Knapp 4534 Avondale St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> <b>4107</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Heart Disease in Pulmon</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Obstructive Emphysema</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>10 yrs</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>72</b>									
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, apt, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 963</b> to <b>Aug 15, 1968</b> that (I) (we) last saw the deceased alive on <b>11 June 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>William H. K. May</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>Aug 15 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>William H. K. May</b>		22e. ADDRESS <b>8218 Wisconsin Ave</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/19/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cem,</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville Mont. Md.</b>			
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		7557 Wisc. Ave. Beth		25a. REC'D BY REGISTRAR <b>AUG 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





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<div>11760</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item #5, 5 Film G10, 9/24/68</div> <div>CERTIFICATE OF DEATH</div>											
DECEASED NAME (Type or print) First Middle Last <b>HOWARD LAWTON KNIGHT</b>						2a. DATE OF DEATH Month 8 Day 19 Year 68		2b. HOUR 10:10 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9/29/92 81		6. AGE in years 76 yrs		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) MONTGOMERY GENERAL HOSP.		12a. USUAL OCCUPATION (Kind of work done during last year if retired, give occupation) RETIRED EDITOR		12b. KIND OF BUSINESS OR IND. EST. GOV'T.					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SANDY SPRG.		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER APT. #E14 1740L NORWOOD RD.			
4. FATHER'S NAME First Middle Last <b>WILLIS --- KNIGHT</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>LYRA --- BRIGHAM</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 215-32-9285		17. INFORMANT MEDICAL RECORDS Address							
18. CAUSE OF DEATH Enter on y one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>Unk</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2. Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) (OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>AUG 17, 1968</b> , to <b>AUG 19, 1968</b> , that (I) (we) lost the deceased alive on <b>AUG 19, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d) (did not) view the body after death											
22b. SIGNATURE <b>Ray A. Olsson, MD</b> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>19 AUG 68</b>					
22d. PHYSICIAN'S NAME (Type) <b>RAY A. OLSSON, M.D.</b>				22e. ADDRESS <b>MEDICAL CENTER, SANDY SPRING, MARYLAND</b>							
23a. BURIAL OR CREMATION REMOVAL (Specify)		23b. DATE <b>8/20/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lawrence Cemetery</b>		23d. LOCATION (City or Town) <b>Rockville</b>		(County) (State)			
24. FUNERAL DIRECTOR <b>J. S. Meyer Jr., Mortician, Inc.</b> ADDRESS				25a. REC'D BY REGISTRAR <b>AUG 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The following requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Classified with Medical Examiner's Report No. 11767-40

11767

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>HELEN LOUISE KOCH</b>			2a. DATE OF DEATH Month <b>AUGUST</b> Day <b>17</b> Year <b>1968</b>			2b. HOUR <b>3:10 A M</b>								
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>October 6, 1877</b>		6 AGE, in years last birthday <b>90</b> YRS		7 UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8 UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>				
7a. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Montgomery</b>					
10 CITY OR TOWN OF DEATH <b>Wheaton</b>			11. NAME OF HOSPITAL OR INST. (If not in hospital give street address) <b>1115 N. Wheaton, 4011 Randolph Rd. Md.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk - Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U. S. GOVT</b>					
13a. U.S. AL. RESIDENCE (Where deceased admission; STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Bethesda</b>			13d. INSPECTION YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>4804 Leland Street</b>		
14 FATHER'S NAME First <b>Martin</b> Middle <b>M.</b> Last <b>Welch</b>			15 MOTHER'S MAIDEN NAME First <b>Helen</b> Middle <b>G.</b> Last <b>Lynch</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>			16b. SOCIAL SECURITY NO. <b>YES</b>			17 INFORMANT Address <b>Winthrop, Mrs. Arthur D'Maley 40 Pico Ave. Mass.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure, acute</b> DUE TO, OR AS A CONSEQUENCE OF 1b. <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b> Approximate interval between onset and death <b>2 days</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Fracture L. hip.</b>														
19a. DATE OF OPERATION <b>June 19 1968</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fract L. hip</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either not by medical examiner)			21b. TIME OF INJURY HOUR <b>10:30 P</b> Month <b>JUNE</b> Day <b>17</b> Year <b>1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) <b>PATIENT TRIPPED + FELL.</b>								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (If HOME, GIVE STREET AND CITY) <b>5025 N 33RD ST FRIEND'S</b>			21f. LOCATION Street or RFD No. City or Town County State <b>5025 N 33RD ST ARNINGTON VA.</b>								
22a. I certify that (this hospital) attended the deceased from <b>7/30, 1968</b> to <b>Aug 16, 1968</b> , that (I) (we) last saw the deceased alive on <b>8/15/68</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE <b>James R. Coleman MD</b>						22c. DATE SIGNED <b>Aug. 17, 1968.</b>			22d. PHYSICIAN'S NAME (Type) <b>9241 COLUMBIAN MD.</b>					
23a. BURIAL CREMATION REMOVED <b>Cremation</b>			23b. DATE <b>Aug. 21, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Crematory</b>			23d. LOCATION (City or Town, County) State <b>Bladensburg P.G. Maryland</b>					
24. FUNERAL DIRECTOR <b>Warner E. Pomphrey, Inc. 8434 Ga. Ave. S.S., Md.</b>						25a. REC'D BY REGISTRAR <b>AUG 22 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in case of death within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11768 CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
Helen Carmen KOESTER						August 1 1968		800A	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE in years last birthday		7 UNDER 24 HRS.	
Female		Caucasian		Dec. 4, 1927		40 YRS.		MON HRS. DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
California		USA				Montgomery		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		2a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		2b KIND OF BUSINESS OR INDUSTRY			
Bethesda		Naval Hospital		Nurse, U. S. Navy					
13a USJA. RESIDENCE (Where deceased lived 1 instant on; Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3a STREET AND NUMBER			
Calif.				Richmond		6110 Fresno Ave.			
14 FATHER'S NAME First Middle Last			5 MOTHER'S MAIDEN NAME First Middle Last						
Martin E. KOESTER			Carmen Jimenez						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or period of service)			16b SOCIAL SECURITY NO.		17 INFORMANT Address				
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> 1955-68			569 46 0940		Navy Records				
18 CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE a) Carcinoma of breast with widespread metastases								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
		P.M. 19							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (X) (this hospital) attended the deceased from May 2 1968 to Aug. 1 1968, that (X) (we) lost saw the deceased alive on Aug. 1 1968 and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.									
22b SIGNATURE				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c DATE SIGNED	
R. W. VIRGILIO, M.D.								Aug. 2, 1968	
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
		Naval Hospital, Bethesda, Md.							
23a BURIAL, CREMATION, or other disposal (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town County State)			
Burial		8-3-68		Oakmont Memorial Park		Pleasant Hills, Calif.			
24. FUNERAL DIRECTOR W. W. Chambers Co.				ADDRESS		25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
1400 Chapin St., N.W. Washington, D. C.						AUG 6 1968		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal of the body. A copy event within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation or removal of the body.

<div>11762</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 9 Film 11762</div> <div>Item 1 Film 11762</div> <div>CERTIFICATE OF DEATH</div>									
1 DECEASED-NAME (Type or print, First Middle Last) <b>MINNIE ELIZABETH KRAFT</b>					2a. DATE OF DEATH <b>8th Month 2nd day 1968</b>			2b. HOUR <b>9:05 AM</b>	
3 SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>SEPT. 27, 1893</b>		4. AGE (In years (last birthday)) <b>74 85 YRS</b>		11 UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CIT. ZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>			
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		NAME OF HOSPITAL OR INSTITUTION, if not in hospital (on street address) <b>POTOMAC VALLEY NURSING HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			
13a. USUAL RESIDENCE (Where deceased lived admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		3c. CITY OR TOWN <b>Rockville</b>		13d. WHICH CITY (WEST)? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		13e. STREET AND NUMBER <b>14205 HI-WOOD DRIVE</b>	
4. FATHER'S NAME First Middle Last <b>JOHN HARMON</b>				5. MOTHER'S MAIDEN NAME First Middle Last <b>MARGARET BEST</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war in which served) <b>No</b>				6b. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Mrs. Dorothy Claggett, Rockville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE <b>PROGRESSIVE CONGESTIVE HEART FAILURE</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>POSSIBLE CORONARY THROMBOSIS</b> DUE TO OR AS A CONSEQUENCE OF <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <b>CHRONIC RENAL FAILURE</b>									
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If yes, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>PM 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (th) s hosp to attended the deceased from <b>March 1960</b> to <b>August 3 1968</b> , that (I, we) last saw the deceased alive on <b>August 1 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d) (d) (d) (d) view the body after death									
22b. SIGNATURE <b>Gordon S. Rosenberg, M.D.</b>				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9 August 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>GORDON S. ROSENBERGER, M.D.</b>		22e. ADDRESS <b>310 West Montgomery Ave. Rockville, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Montg. Maryland</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>7557 Wisconsin Ave. Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial or cremation, and in any event within 72 hours after death.

11770

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type or Print) <b>GARY ROBERT KRASS</b>			2a. DATE KNOWN OF DEATH Month <b>Aug</b> Day <b>15</b> Year <b>1968</b>			2b. MO. R. <b>5 AM</b>		
3 SEX <b>male</b>	4 RACE <b>W</b>	5 DATE OF BIRTH <b>6/20/48</b>	6 AGE In years (in birthdate) <b>20</b> YRS	7a. MONTHS <b>15</b>	7b. DAYS <b>15</b>	7c. HOURS <b>5</b>	7d. MIN <b>AM</b>	2c. DATE PROMOUNCED DEAD Month <b>Aug</b> Day <b>15</b> Year <b>1968</b>
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11 NAME OF HOSPITAL OR INSTITUTION, if not in hospital give street address <b>Suburban Hospital</b>			12a. SOCIAL OCCUPATION (if not at work state day no most at working if even if retired) <b>U.S. Marine Active</b>		
13a. SOCIAL RESIDENCE Where deceased lived if institution or residence before admission STATE <b>Ohio</b> COUNTY <b>Cincinnati</b>			13b. CITY OR TOWN <b>Cincinnati</b>			13c. STREET AND NUMBER <b>6837 SAVANNAH</b>		
14. FATHER'S NAME First <b>Edward</b> Middle <b>KRASS</b> Last <b>KRASS</b>			15 MOTHER'S M.A.D.E.N. NAME First <b>CHARA</b> Middle <b>MARTHA</b> Last <b>FRESON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <b>yes</b> <b>1966-1968</b>			16b. SOCIAL SECURITY NO <b>UNKNOWN</b>			17 INFORMANT <b>1801 DANA AVE - Cincinnati, Ohio. HAROLD WORK - step father.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple Injuries Severe -</b> <b>816.0</b> (and list any which gave rise to immediate cause (a), stating the underlying cause last) (b) <b>Trauma from Auto Accident.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN DEATH AND D.A.M. <b>29h.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>12b. AM 9/14/68</b>			21b. TIME OF INJURY Month Day Year <b>12b. AM 9/14/68</b>			21c. HOW INJURY OCCURRED Enter nature of injury in Part 1 or Part 2, Item 8 <b>lost control of car - turned over.</b>		
22a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			22b. PLACE OF INJURY A home farm street factory office building, etc. <b>Highway</b>			22c. LOCATION Street or R.F.D. No City or town County State <b>495 + 270 - Bethesda Montgomery Md</b>		
22a. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John G. Ball</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>Aug 15, 1968</b>		
EXAMINER'S NAME (Type) <b>John G. Ball, M. D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street city town or county) <b>Cincinnati, Ohio</b>			ADDRESS (Street city town or county) <b>Cincinnati, Ohio</b>			ADDRESS (Street city town or county) <b>Cincinnati, Ohio</b>		
23a. BURIAL CREMATION <b>Burial</b>			23b. DATE <b>8-20-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>CINCINNATI, OHIO</b>		
24 FUNERAL DIRECTOR <b>W. W. Chambers Co.</b>			ADDRESS <b>1400 Chapin St.</b>			25a. REC'D BY REG. STRAR <b>AUG 19 1968</b>		
N.W., Washington, D. C.			25b. REGISTRARS SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and camp etc. y filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

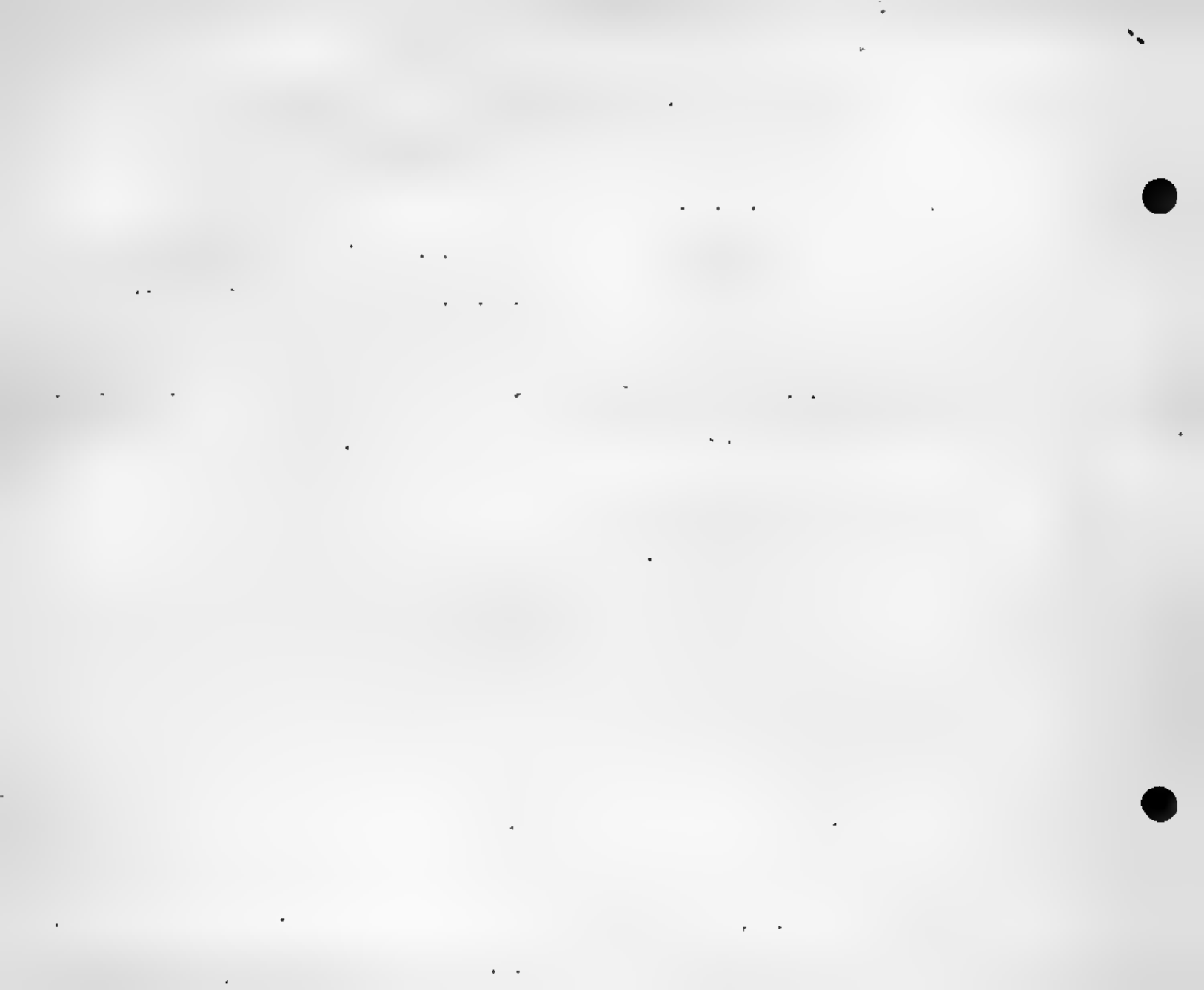
11772

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11778

1 DECEASED NAME Type or print		First Middle Last		2a DATE OF DEATH		2b HOUR	
George		D. Lane		Month 8 Day 4 Year 68		2 P M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years)		7 IF UNDER 1 YEAR	
Male	White	Jan. 4, 1894		74 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
N. Carolina		U. S. A.		Montgomery		Me	
10 CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (Not in hospital give street address)		12a U.S.A. OCCUPATION Kind of work done during most of working life, even if retired.		2b KIND OF BUSINESS OR INDUSTRY	
Chevy Chase, Md.		Bethesda Silver Spring N.H.		Salesman		Comptometer	
13a S.A. RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d HOUSE CITY AND ST	
Jab		wash. D. C.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
						306 Tilden St., N.W.	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO	
First Middle Last		First Middle Last		Yes, no (unknown) (If yes give year or dates of service)		Address	
William T. Lane		Mary Elizabeth Olt		Yes, no (unknown) W.W. I		324-09-2551	
				17 INFORMANT		Address	
				W. T. Richter, 5510 Sanger Ave. Alex., Va.			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions (if any) which gave rise to immediate cause (a) stating the underlying cause 1117 DUE TO, OR AS A CONSEQUENCE OF 19b 19c							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Diabetes Mellitus</u>							
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If neither notify medical examiner)		HOUR A.M. Month Day Year P.M. 19					
22a. INJURY OCCURRED		22b. PLACE OF INJURY (AT HOME, FARM, STREET, ACTORY) (OF ICE BUILDING ETC)		22c. LOCATION Street or R.F.D. No. City or Town County State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
22a. I certify that (1) (this hospital) attended the deceased from <u>1-6-68</u> to <u>8-5-68</u> that (1) (we) last saw the deceased alive on <u>7-16-68</u> and that in (my (your) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
<u>Stanley M. Silverberg</u>		<u>8-5-68</u>		Stanley M. Silverberg, M.D. 5201 Conn. Ave., N.W.			
22e. ADDRESS		22f. DATE SIGNED		22g. REGISTRAR'S SIGNATURE			
				<u>Joseph Gawler's Sons, Inc.</u>			
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) State	
Burial		Aug. 7, 1968		Arlington National		Arlington, Arlington, Va.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE	
Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W.		AUG 7 1968		<u>Joseph Gawler's Sons, Inc.</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

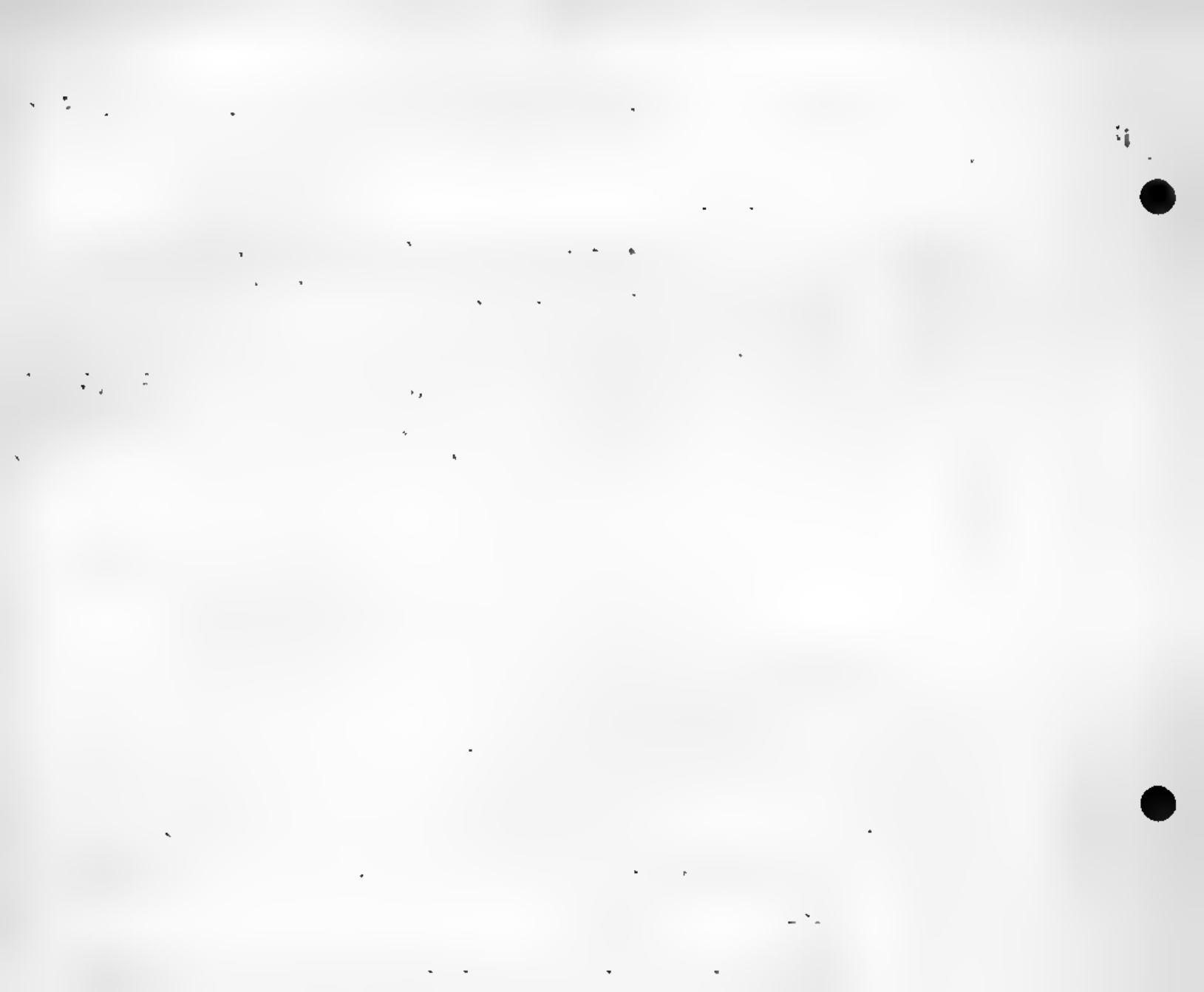
117772

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11779

DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Eleanor		B.	Lanning	Month Day Year Aug. 29 1968		5:30 PM		
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Female	White		8-2-1890		78 YRS.		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
N. Jersey		U.S.A.				Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			2a. USUAL OCCUPATION (Kind of work done during most of working life; even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring			Holy Cross Hospital			Hamilton & Leck		Hospital
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. RESIDE IN INSTITUTION? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Montgomery		Sil. Spr.		2504 Henderson Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
First Middle Last Charles W. Lanning			First Middle Last Belle Dalrymple					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No (If unknown)			194-26-1510		Margaret Lanning		2504 Henderson Avenue Sil. Spr., Md.	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 4101 DUE TO, OR AS A CONSEQUENCE OF (b) <u>28 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>diabetes, generalized arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 29</u> 19 <u>68</u> to <u>Aug 29</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug 29</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (d) (did) (hat) view the body after death								
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
Patrick Jameson								8/29/68
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
Patrick Jameson, Md.				11718 Georgia Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town (County) (State)		
Burial		9-2-1968		Presbyterian Cemetery		Hampton New Jersey		
24. FUNERAL DIRECTOR				25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Lester E. Wampler, Inc. 8434 Ga. Ave. Sil. Spr. Md.				SEP 5 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11773

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Alfred (NMN) Laudan</b>			2a DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1968</b>			2b HOUR <b>PM</b> <b>1:20</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>21 August 1926</b>		6 AGE, in years (last birthday) <b>42</b> YRS.		7 UNDER 24 HRS. MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <b>New Jersey</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b> Md.				
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		NAME OF HOSPITAL OR INSTITUTION (not in hospital give street address) <b>The Clinical Center, NIH</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired, Superintendent)		12b KIND OF BUSINESS OR INDUSTRY <b>City Gov't</b>			
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) <b>New Jersey</b>			13b COUNTY <b>--</b>		13c CITY OR TOWN <b>Maywood</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>128 Park Avenue</b>	
14 FATHER'S NAME First Middle Last <b>Adolf Laudan</b>			15 MOTHER'S M A DEN NAME First Middle Last <b>Gertrude Hallang</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or date of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown, <b>1944-1946</b>			16b SOCIAL SECURITY NO <b>Not available</b>		7 INFORMANT <b>The Medical Record</b> address <b>The Clinical Center, Bethesda, Md. 20014</b>					
18 CAUSE OF DEATH (Enter only one cause per line for a, b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningitis - etiology unknown</b> <b>3209</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO OR AS A CONSEQUENCE OF (c) _____ Candidans, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. ex. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (A) (this hospital) attended the deceased from <b>July 16</b> , 19 <b>68</b> to <b>August 31</b> 19 <b>68</b> , that (B) (we) last saw the deceased alive on <b>August 31</b> 19 <b>68</b> , and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>David C. Dale MD</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>31 August 1968</b>		
22d. PHYSICIAN'S NAME (Type, <b>David C. Dale, M.D.</b>				22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>						
23a. BURIAL, CREMATION, <b>Burial</b>		23b. DATE <b>9/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Washington Mem.</b>		23d. LOCATION (City or town) <b>Maywood</b>		(County) <b>New Jer-</b> sey.		
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>				25a ADDRESS <b>7557 Wisconsin Ave</b>		25b REC'D BY REGISTRAR <b>SEP 10 1968</b>		25c REG. CLERK'S SIGNATURE <b>Charles Judge</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV 1-68

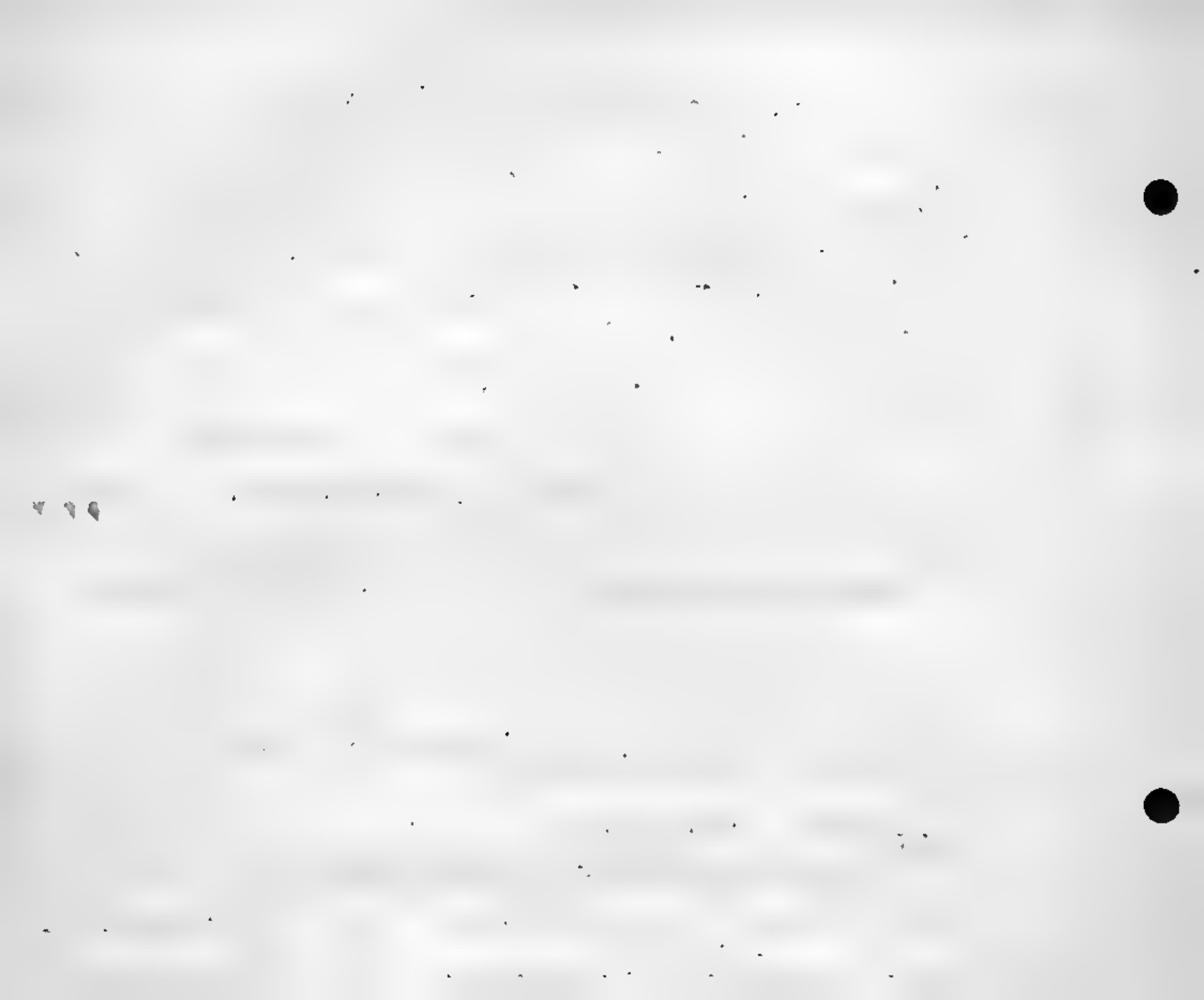
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11772

781

1. DECEASED-NAME (Type or print) <b>Louise <del>Esperanza</del> B. Lenet</b>			2a. DATE OF DEATH <b>August 21 1968</b>			2b. HOUR <b>4:15</b> AM	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>3-11-22</b>		6. AGE (In years last birthday) <b>46</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County Md</b>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If home, give street address) <b>Washington Sanitarium</b>		12a. S.W.A. OCCUPATION Kind of work done during most of working life, even if retired. <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission). STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>Walter</b> Middle <b>E.</b> Last <b>Buckner</b>		15. MOTHER'S M maiden name First <b>Essie</b> Middle <b>Dunkley</b> Last <b>Dunkley</b>					
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO <b>227-18-6339</b>		17. INFORMANT <b>Patients Record</b>		Address	
B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intra cerebral Hemorrhage</b> <b>4307</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Rupture of Aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>48 hr</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIB. TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <b>Brain Subarachnoid Hemorrh. over past 2+ wks</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OF CONTRIB. ING <input type="checkbox"/> CAUSE OF DEATH (If either not a medical examiner)		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year <b>19</b>		21. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2. Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-13 1968</b> to <b>Aug 21, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 20 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d d) (d d) view the body after death							
22b. SIGNATURE <b>Jonathan M. Williams</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8-21-68</b>	
22d. PHYSICIAN'S NAME TYPE <b>Jonathan M. Williams</b>		22e. ADDRESS <b>808 Pershing Dr. Sil. Spr</b>					
23a. BURIAL CREMATION OR REMOVAL <b>burial</b>		23b. DATE <b>8-23-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>Warner E. Humphrey, Inc.</b>		C. Glen Carter		25a. REC'D BY REGISTRAR <b>AUG 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal and in any event within 72 hours after death).

11775

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

82

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Angela Liappi</i>			2a. DATE OF DEATH Month <i>8</i> Day <i>31</i> Year <i>68</i>			2b. HOUR <i>9 PM</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>8-30-68</i>		6. AGE (in years last birthday) <i>26</i> YRS		7. UNDER 1 YEAR MONTHS <i>1</i> DAYS <i>1</i>		
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md				
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp</i>			12a. USUAL OCC. PAT. ON Kind of work done during most of working life even if retired			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Washington D.C.</i>			13c. CITY OR TOWN <i>District of Columbia</i>			13d. INSURE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>2458 Tunlaw N.W.</i>	
14. FATHER'S NAME First Middle Last <i>Bill N. Liappi</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Margaret Agnes Farmer</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address <i>mother</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hyaline Membrane disease</i> <i>7701</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>abruptio placenta</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>31 hrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING TO CONTRIBUTING ( ) CAUSE OF DEATH (If either notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>8-30-68</i> , 19 <i>68</i> , to <i>8-31-68</i> that (I) (we) last saw the deceased alive on <i>8-31-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <i>Donald Straus</i> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>8/31/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Donald Straus</i>						22e. ADDRESS				
23a. B.U.R.I. CREMATION REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>9/4/68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Md.</i>	
24. FUNERAL DIRECTOR <i>LYSON WHEELER</i>			F.N. <i>1331</i> ADDRESS <i>Rockville Md</i>			25a. REC'D BY REGISTRAR <i>SEP 6 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Colonel notified & appeared

1

11776

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

117763

CERTIFICATE OF DEATH

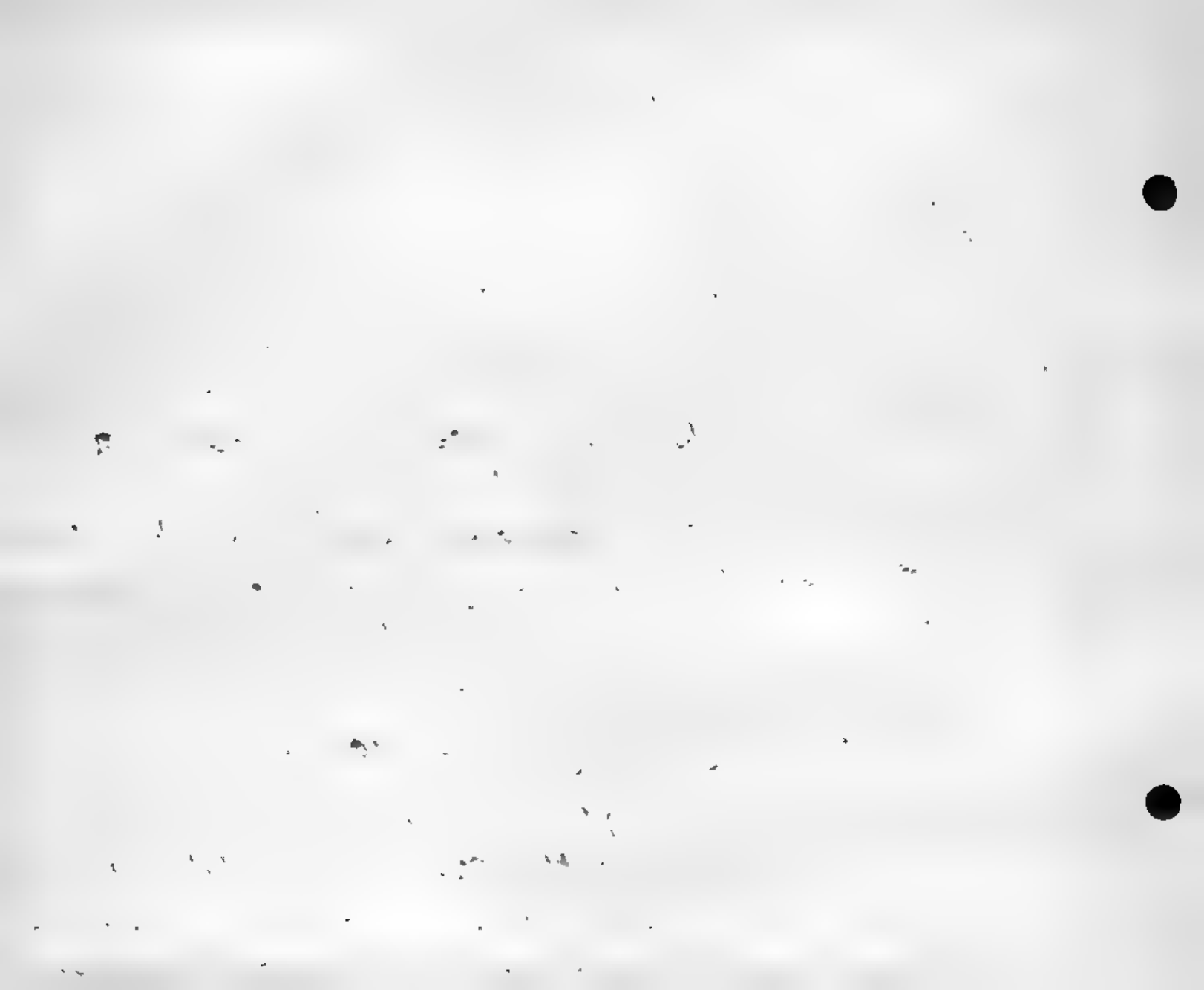
1 DECEASED NAME (Type or print) First Middle Last Rufus Cash Lipscomb			2a. DATE OF DEATH Month Day Year Aug 17 68		2b. HOUR 8:30AM
3 SEX Male	4 RACE White	5. DATE OF BIRTH 7/18/82		6. AGE (in years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. COUNTY OF DEATH Montgomery Md.			9b. COUNTY OF DEATH		
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wash San & Hospital		2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired from navy yard	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission: STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	3a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3b. STREET AND NUMBER 715 Richmond Ave
14 FATHER'S NAME First Middle Last John M. Lipscomb			5 MOTHER'S MAIDEN NAME First Middle Last Annie M. Kelly		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) yes WW 1		16b. SOCIAL SECURITY NO 220-44-2072		17 INFORMANT Mrs. Lena Lipscomb 715 Richmond Ave Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: <u>Atherosclerosis of Heart Arteries</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 yrs.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 20, 1958</u> to <u>Aug 17, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Aug 17, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d) (did not) view the body after death					
22b. SIGNATURE <u>Russell B. Arnold, MD</u>				22c. DATE SIGNED <u>17 Aug, 1968</u>	
22d. PHYSICIAN'S NAME (Type) Russell B. Arnold, MD.				22e. ADDRESS 1106 Spring Street, Sil. Spr., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 22, 1968		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
23d. LOCATION (City or Town) Washington, D. C.		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc. 8434 Ga. Ave. S.S., Md.				25a. REC'D BY REGISTRAR DATE AUG 23 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge				25c. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) <b>Anna</b> First <b>Clein</b> Middle <b>Lobban</b> Last						2a DATE OF DEATH <b>8</b> Month <b>5</b> Day <b>68</b> Year			2b HOUR <b>6p</b> M.			
3. SEX <b>Female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH <b>10/9-9A</b>		6 AGE in years last birthday <b>76</b> YRS.		7 UNDER YEAR MON. WED. DAYS		8 UNDER MRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>N. J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D. WORKED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.						
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON SW + H&amp;S</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired, <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY						
3a. USUAL RESIDENCE (Where deceased lived if in institution: Residence before admission, STATE <b>MARYLAND</b>		3b. COUNTY <b>MONTGOMERY</b>		3c. CITY OR TOWN <b>TAKOMA PARK</b>		3d. INSIDE CITY, UNIT? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e. STREET AND NUMBER <b>8500 FLOWER AVE</b>				
4. FATHER'S NAME First <b>FREDERICK</b> Middle <b>LAKE</b> Last <b>FLORENCE ISABELLE</b>		5. MOTHER'S MAIDEN NAME First <b>NORTHROP</b> Middle <b>LAKE</b> Last <b>FLORENCE ISABELLE</b>		6. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b> Yes, no, or unknown <input type="checkbox"/> If yes give year or dates of service		7. SOCIAL SECURITY NO. <b>152-10-8474D</b>		8. INFORMANT <b>HOSPITAL RECORDS</b>		9. ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory &amp; Cardiac Arrest</b> DUE TO OR AS A CONSEQUENCE OF Terminal <b>Terminal</b> Conditions (any which gave rise to immediate cause (a), noting the underlying cause last) DUE TO OR AS A CONSEQUENCE OF <b>Pulmonary edema due to congestive heart failure</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Coronary Thrombosis &amp; Complete Occlusion 2 yrs ago</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>		
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>9</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)		21d. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (i) (this hospital) attended the deceased from <b>1966</b> to <b>Aug 5, 1968</b> , that (j) (we) last saw the deceased alive on <b>Aug 5, 1968</b> , and that (k) (my) (our) opinion death occurred on the date and hour and from the causes stated above (i) (we) (did) (did not) view the body after death		22b. SIGNATURE <b>Wilford D. Meyers M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Aug 5, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Wilford D. Meyers M.D.</b>		22e. ADDRESS <b>8323 Haddon Dr Takoma Park Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>rockville Mont. Md.</b>						
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>Aug 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>Aug 8 1968</b>						





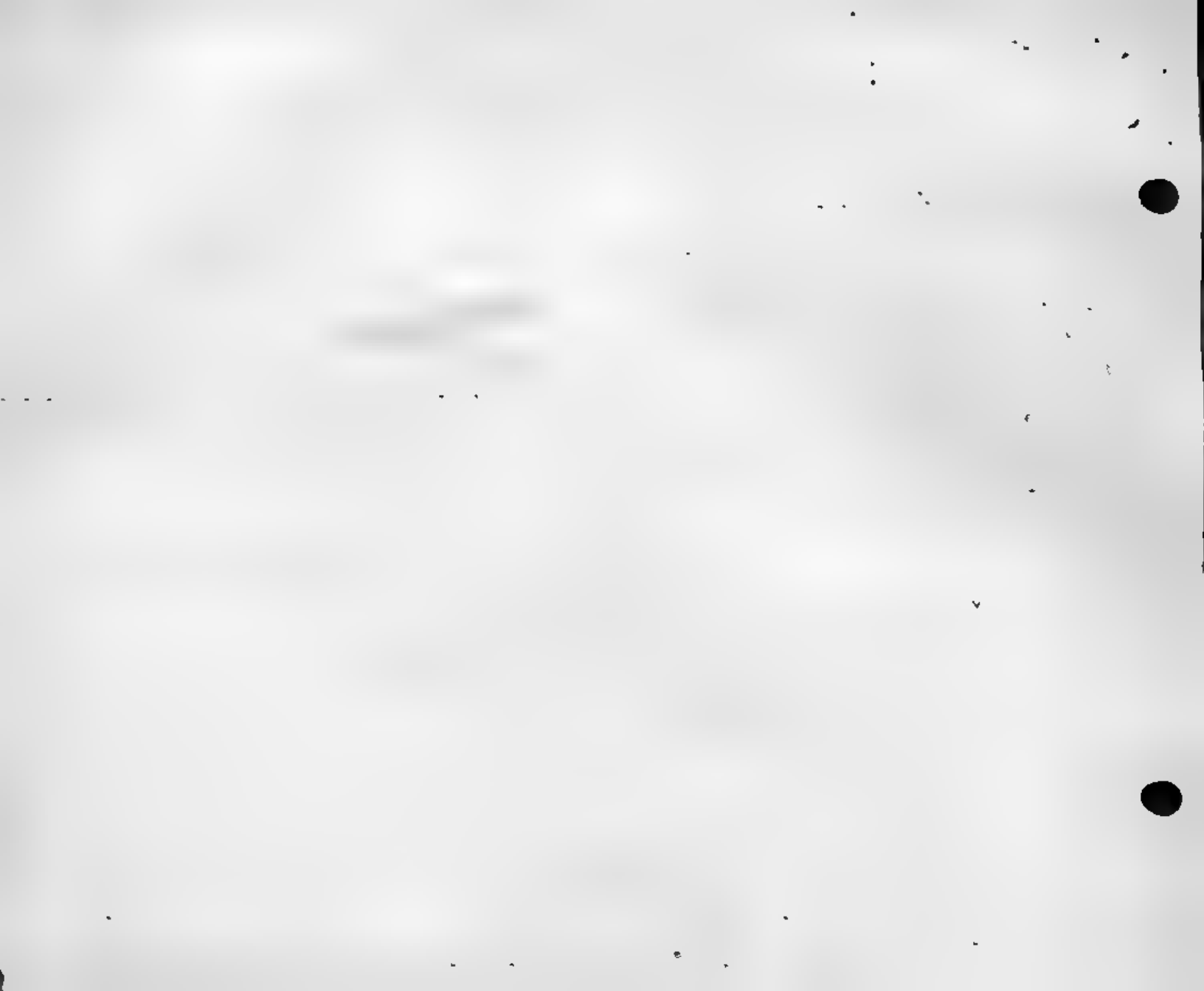
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate within the word "pending" in space for item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECEASED NAME (Type or Print) First Middle Last <b>NANCY ELLEN LOTZ</b>				2a. DATE KNOWN OF DEATH Month Day Year <b>8-24-68</b>				7b. HOUR OF DAY <b>6P</b>	
3. SEX <b>Fe</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH Month Day Year <b>12-6-55</b>		6. AGE In years Months Days <b>12 YRS</b>		7. DATE PRONOUNCED DEAD Month Day Year <b>8-24-68</b>	
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF H. SP. A. OR INSTITUTION (If not in hospital give street address) <b>8900 PINEY BR.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>SCHOOL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Student</b>	
13a. JSLA. RES. DENCE (Where deceased lived, if institution, Res. dence before admission) STATE <b>MD.</b>		13b. COUNTY <b>MONTG</b>		13c. CITY OR TOWN <b>SIL. SPR.</b>		13d. ST. NO. & ST. NAME <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>8930 PINEY BR. RD.</b>	
4. FATHER'S NAME First Middle Last <b>William W. LOTZ</b>				5. MOTHER'S M. A. D. N. NAME First Middle Last <b>May Janet Naderhoff</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Mrs. M. Janet Lotz 8930 Piney Branch Rd. S.S.</b>			
18. CAUSE OF DEATH (Enter only one cause per line; (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO OR AS A CONSEQUENCE OF <b>due to Electrocutation</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <b>lost</b> (b) <b>due to Electrocutation</b> DUE TO OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE <input type="checkbox"/> <b>6088-8-24-68</b>				21b. T.M. OF INJURY Month Day Year <b>6088-8-24-68</b>		21. HOW INJURY OCCURRED (Describe nature of injury in Part 2) <b>Deceased child climbing tree &amp; touched electric wire</b>			
21d. INJURY OCCURRED Where: <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> <b>Street</b>				21e. PLACE OF INJURY At home, arm, street, or other <b>Street</b>		21f. LOCATION Street or RFD No. City or town County State <b>Tr. 8900 Piney Br. S.S. Montg. Md.</b>			
22a. I certify that I took charge of the remains described above held on. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Type) <b>Rockville, Md.</b>				22b. DATE SIGNED <b>Aug. 24, 1968</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) County State <b>Rockville Montg. Md.</b>			
24. FUNERAL DIRECTOR <b>M. Andrew Duwall Warner E. Pumphrey Inc. 8434 Georgia Ave. S.S.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial or transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, with in 72 hours after death.

VR 115 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print) <b>EVA</b>			First		Middle <b>Mae</b>		Last <b>LYNCH</b>		2a. DATE OF DEATH Month <b>8</b> Day <b>29</b> Year <b>1968</b>			2b. HOUR <b>2</b> PM	
3. SEX <b>F.</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>2-19-94</b>			6. AGE (In years last birthday) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>10</b>		IF UNDER 24 HRS. HOURS <b>2</b> MIN <b>00</b>		
7a. BIRTHPLACE (State or foreign country) <b>N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.						
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>St. Vincent's Hospital</b>			2c. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>M.D.</b> 13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1207 Bluehill Rd.</b>						
4. FATHER'S NAME First <b>George</b> Middle <b>Genson</b> Last <b>Grant</b>			5. MOTHER'S MAIDEN NAME First <b>Cora</b> Middle <b>Grant</b> Last <b>Grant</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO. <b>12807 Bluehill Rd.</b>			17. INFORMANT <b>Mrs. Clifford White</b> Address <b>Wheaton, Md.</b>	
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE <b>arteriosclerotic heart disease</b>													
DUE TO, OR AS A CONSEQUENCE OF <b>a. Cardiac arrhythmia</b>													
DUE TO, OR AS A CONSEQUENCE OF <b>(c)</b>													
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4</b>													
9a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <b>10</b> Month <b>8</b> Day <b>29</b> Year <b>1968</b> P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (A) HOME (B) STREET (C) FACTORY (D) OFFICE BUILDING, ETC. <b>Home</b>			21f. LOCATION Street or R.F.D. No <b>1207</b> City or Town <b>Rockville</b> County <b>Montgomery</b> State <b>Md.</b>							
22a. I certify that (I) (the hospital) attended the deceased from <b>2-29-68</b> 19 <b>68</b> , to <b>2-29-68</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>2-29-68</b> 19 <b>68</b> , and that in (day) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE <b>Dr. Lewis H. Dennis</b>			22c. PHYSICIAN'S NAME (Type) <b>Dr. Lewis H. Dennis</b>			22d. ADDRESS <b>3906 Beebe Rd. Silver Spring, Md.</b>			22e. DATE SIGNED <b>2-29-68</b>				
23a. BURIAL, CREMATION, REMOVAL, SPECIES <b>Burial</b>			23b. DATE <b>8-29-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>				
24. FUNERAL DIRECTOR <b>Warner E. Humphrey, Inc. 8434 Ga. Ave., Sil. Spr.</b>						25a. REC'D BY REGISTRAR <b>AUG 30 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

MED. CAL. CERT. F. CAT. ON



CERTIFICATE OF DEATH

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DECEASED-NAME (Type or print) <u>TRICIA</u> First <u>CLINE</u> Middle <u>MARYS</u> Last			2a. DATE OF DEATH Month <u>Aug</u> Day <u>8</u> Year <u>1968</u>			2b. MOJR <u>11:5 PM</u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>5/26/45</u>		6. AGE (in years less birthday) <u>23</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban Hospital</u>		2a. JSAL OCC SPAT ON (kind of work done during most of working life even if retired)		2b. KIND OF BUSINESS OR INDUSTRY	
3a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) <u>Maryland</u> STATE		13a. CITY OR TOWN <u>Bethesda</u>		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b. STREET AND NUMBER	
14. FATHER'S NAME First <u>Charles</u> Middle <u>Bernard</u> Last <u>DePoe</u>		15. MOTHER'S MAIDEN NAME First <u>Larry</u> Middle <u>Hazel</u> Last <u>Pearson</u>					
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u>		16a. SOCIAL SECURITY NO <u>217-507692</u>		17. INFORMANT <u>Henry Lynn Marys - husband</u>			
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c); PAR* DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain Tumor (Primary) From</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u></u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>237 X</u>							
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING? OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u></u> Month <u></u> Day <u></u> Year <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (If home, EARNE STREET FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No <u></u> City or Town <u></u> County <u></u> State <u></u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/26/45</u> 19 <u>48</u> to <u>8/8/68</u> 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>8/8/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <u>Charles Judge</u> DEGREE <u></u> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>Aug 12 1968</u>			
22d. PHYSICIAN NAME (Type) <u>4977 Bethesda</u>				22e. ADDRESS <u>Bethesda Md.</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>		23b. DATE <u>Aug 11, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD BAPTIST</u>		23d. LOCATION (City or Town) (County) (State) <u>GLENWOOD HOWARD MD</u>	
24. FUNERAL DIRECTOR <u>Waggoner &amp; Sons</u>		25a. RECD BY REG-STRAR <u>Charles Judge</u>		25b. REC-STRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 12 1968</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please sign over carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and on any event within 72 hours after death.

11780

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF EST. DEATH		Month	Day	Year	2b HOUR
Mabel Elizabeth Mansuy					8-18-68		8	18	1968	4:30 P.M.
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day
Female	White	April 5, 1890		78 YRS	MONTHS	DAYS	8-18-68		1968	4:30 P.M.
7a BIRTHPLACE State or foreign (country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY		
Illinois		U.S.A.		WIDOWED		Montgomery		Own Home		
10 CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				20 USUAL OCCUPATION Kind of work done during most of working life even if retired		12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring		9110 Bradford Road				Housewife		Own Home		
13a USUAL RESIDENCE Where deceased lived (include address)		13b COUNTY		13c CITY OR TOWN		3d STREET AND NUMBER		3e STREET AND NUMBER		
Md.		Montgomery		Sil. Spring		9110 Bradford Road		9110 Bradford Road		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16 WAS DECEASED EVER IN U.S. ARMED FORCE?		17 INFORMANT		18 ADDRESS		
Frank M. Gritton		Cynthia Daley		NO		Mr. John A. Mansuy		9110 Bradford Road		
19 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		4129 Acute Coronary Insufficiency								
DUE TO OR AS A CONSEQUENCE OF (b)		Arteriosclerotic Heart Disease								
DUE TO OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
4201										
21a DATE OF OPERATION		21b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXT. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month Day Year		22 HOW INJURY OCCURRED (Enter nature of injury in Part 2 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street & R.F.D. No		City or Town		County		State
22a I certify that I took charge of the remains described above. I did an Autopsy <input type="checkbox"/> Inspect an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b DATE SIGNED								
ACTUAL SIGNATURE		22c NAME OF CEMETERY OR CREMATORY		23a LOCATION (City or Town)		County		State		
Belden R. Reap M.D.		August 21, '68		St. Mary's Cath. Cemetery		Washington		D.C.		
EXAMINER'S NAME (Type)		24 FUNERAL DIRECTOR		25a REC'D BY REG. STRAR		25b REG. STRAR'S SIGNATURE		DATE		
Belden R. Reap M.D.		M. Andrew Ewald		AUG 22 1968		Charles J. Juge				



204  
100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>BABY Boy MARTIN</b>						2a. DATE OF DEATH Month <b>Aug</b> Day <b>29</b> Year <b>68</b>			2b. HOUR <b>5:47</b> M		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>8/28/68</b>		6. AGE (in years last birthday) <b>1</b> YRS		7. UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>12</b>		8. UNDER 24 HRS HOURS <b>12</b> MIN <b>33</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL OR INSTITUTION, if not in hospital give street address <b>SUBURBAN</b>			12a. U.S.A. OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>9200 BARDON ROAD</b>		
14. FATHER'S NAME First <b>Virginia</b> Middle <b>MARTIN</b> Last				15. MOTHER'S MAIDEN NAME First <b>MARTIN</b> Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address							
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Prematurity (800 grams)</b> <b>1777X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>23 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>7776X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Frank M. Tate Jr.</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>8/30/68</b>					
22d. PHYSICIAN'S NAME Type				22e. ADDRESS							
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE <b>8/30/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Suburban Hospital</b>		23d. LOCATION (City or Town) (County) (State) <b>Bethesda - Montgomery - Md</b>					
24. FUNERAL DIRECTOR <b>Mrs. Amelia C. Carter, Administrator</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>SEP 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

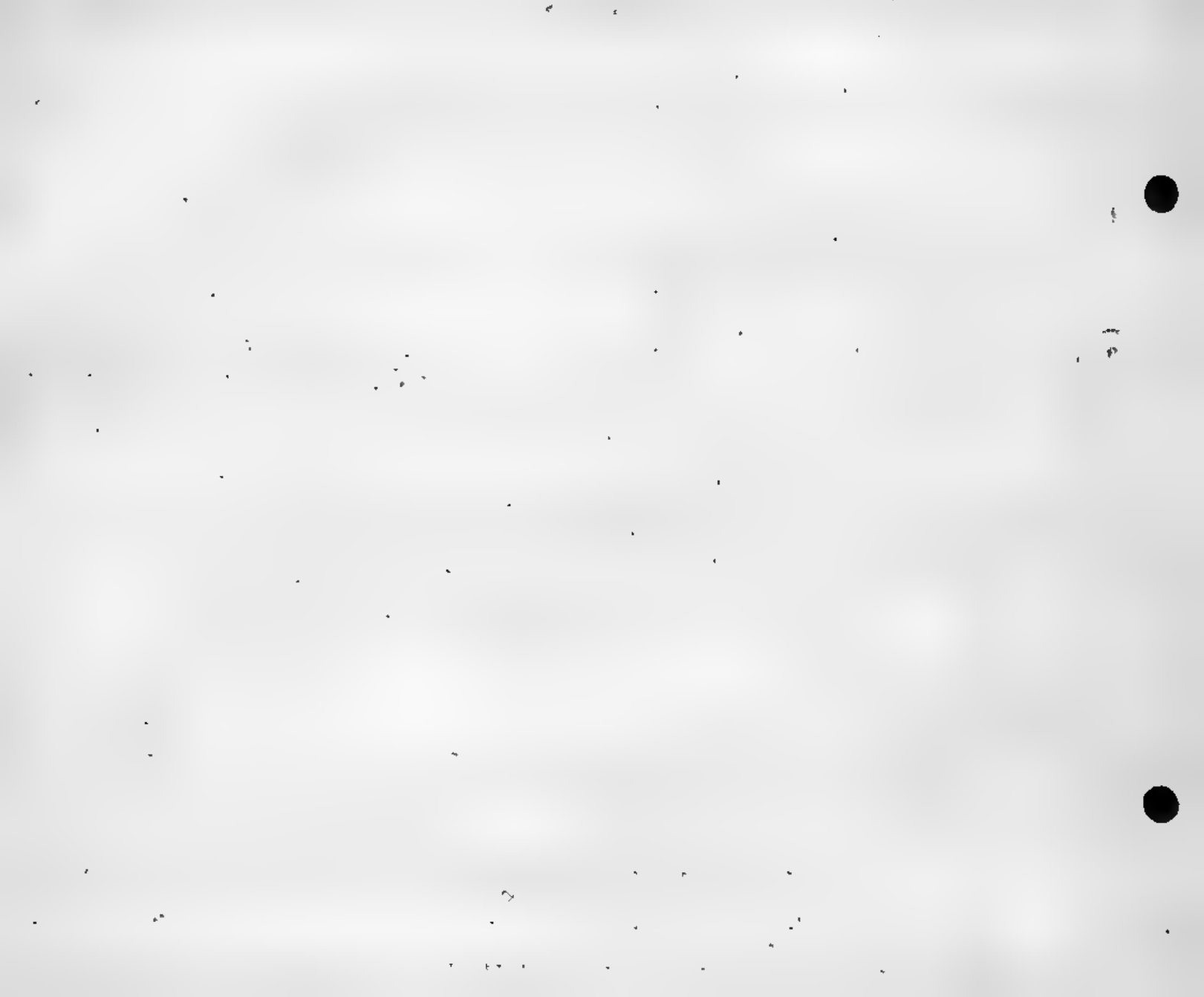


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 415  
3044 REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <sup>First</sup> Ethel <sup>Middle</sup> Hallett <sup>Last</sup> MASON						2a DATE OF DEATH <sup>Month</sup> Aug <sup>Day</sup> 20 <sup>Year</sup> 1968			2b HOUR 9:15 AM		
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH Jan. 25, 1887		6 AGE in years (last birthday) 81		7b UNDER 24 HRS		7c UNDER 24 HRS	
7a BIRTHPLACE (State or foreign country) Arkansas		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			10 KIND OF BUSINESS OR INDUSTRY		
10 CITY OR TOWN OF DEATH Takoma Pk.		NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington San. & Hosp.		2a SOCIAL OCCUPATION (Kind of work done during most of working life even if retired)		2b HOUSEWIFE			10 KIND OF BUSINESS OR INDUSTRY		
13a STATE RESIDENCE (Where deceased had abode) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Burtonsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3a STREET AND NUMBER 3020 Miles Rd.			
14 FATHER'S NAME <sup>First</sup> John <sup>Middle</sup> H. <sup>Last</sup> Coblentz		15 MOTHER'S MAIDEN NAME <sup>First</sup> Addie <sup>Middle</sup> Mac <sup>Last</sup> Hallett		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or Unknown? No		16b SOCIAL SECURITY NO none		17 INFORMANT Mr. Philip Mason Address Sil. Spr., Md. Hosp. & Record			
18 CAUSE OF DEATH Enter only one cause per line for a), b), and c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema 412.9 DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF 1) year 2										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 days 2-3 wks year 2	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Probable cerebral vascular occlusion; impending uremia											
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from 7-22-68 to 8-20-68, that (II) (we) last saw the deceased alive on 8-19-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b SIGNATURE John R. Spencer, MD DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 8-20-68					
22d PHYSICIAN'S NAME (Type) John R. Spencer, MD.				22e ADDRESS 15444 Columbia Road, Burtonsville, Md.							
23a BURIAL, CREMATION, REMOVAL, SPECIFY		23b DATE Aug. 22, 1968		23c NAME OF CEMETERY St. Mark's Episcopal		23d LOCATION (City or Town) Fairland		County Montgomery		State Md.	
24 FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S., Md.				25a REC'D BY REGISTRAR DATE AUG 23 1968		25b REGISTRAR'S SIGNATURE Charles Judge					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 24-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal and in any event within 72 hours after death.

11783

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type or Print) <b>Mark Mathwig</b>			2a DATE KNOWN JF EST DEATH MATED <input checked="" type="checkbox"/> <b>Aug 23 1968</b>			2b MO JR <b>26</b>		
3 SEX <b>male</b>	4 RACE <b>white</b>	5 DATE OF BIRTH <b>June 17 1947</b>	6 AGE in years last birthday <b>21</b> YRS	7 IF UNDER 24 HRS MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month <b>Aug</b> Day <b>23</b> Year <b>1968</b>			2d MO JR <b>26</b>
7a BIRTHPLACE State or foreign country <b>Pa.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>		
8 CITY OR TOWN OF DEATH <b>Bethesda</b>		1 NAME OF HOSPITAL OR INSTITUTION (not in hospital give street address) <b>Suburban Hospital</b>		2a USUAL OCCUPATION (kind of work done during most of work life even if retired) <b>Manager</b>		2b KIND OF BUSINESS OR INDUSTRY <b>Theater</b>		
3a S.A. RESIDENCE (where deceased lived longest prior to residence before admission) STATE <b>Maryland</b>		3b COUNTY <b>Montgomery</b>		3c CITY OR TOWN <b>Bethesda</b>		3d STREET AND NUMBER <b>4757 Chevy Chase Dr. Apt 10</b>		
4 FATHER'S NAME First Middle Last <b>Martin T. Mathwig</b>		5 MOTHER'S MAIDEN NAME First Middle Last <b>Bernice Parkins</b>						
6a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes No, or UNKNOWN)		6b SOCIAL SECURITY NO <b>213-48-0237</b>		17 INFORMANT <b>Bethesda Police</b>		ADDRESS		
18a CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gun-shot wound of heart</b> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <b>22a</b>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month Day Year <b>4:00 AM Aug 23 1968</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18) <b>Was shooting at Police officers and was shot in chest when officer returned fire.</b>		
22a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			22b PLACE OF INJURY (A home town street factory office building, etc) <b>apartment building</b>			22c LOCATION Street or RFD No City or Town County State <b>4757 Chevy Chase Dr. Bethesda Montgomery Md</b>		
22a I certify that, took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John G. Ball</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED - <b>Aug 23 1968</b>		
EXAMINER'S NAME (Type) <b>John G. Ball</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
			ADDRESS (Street City town or county)					
23a BURIAL CREMATION REMOVAL <b>Burial</b>			23b DATE <b>8-26-68</b>			23c NAME OF CEMETERY OR CREMATORY <b>Rest Haven Mem. Gard. Nr. Frederick Fred. Co</b>		
24 FUNERAL DIRECTOR <b>Raymond E. Creager</b>			25a REC'D BY REGISTRAR <b>Aug 26 1968</b>			25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





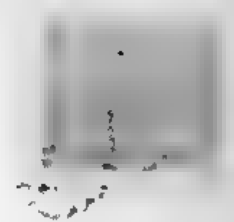
11784

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <b>Luella H. MAY</b>			2a DATE OF DEATH Month Day Year <b>August 6 1968</b>			2b HOUR <b>328 PM</b>			
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH <b>May 18, 1894</b>		6 AGE, in years last birthday YRS <b>74</b>		IF UNDER 1 YEAR MONTH DAYS IF UNDER 74 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>			Mid
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>			12a USUAL OCCUPATION Kind of work done during most of working life (e.g. "eye" "retired") <b>Clerk/Housewife</b>			12b KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
13a USUAL RESIDENCE (Where deceased lived admission) STATE <b>D. C.</b>		13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Washington</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>2306 41st St., N.W.</b>	
4 FATHER'S NAME First Middle Last <b>Edwin D. Wordell</b>				5 MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth A. Taylor</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, on or unknown, <input type="checkbox"/> If yes give war or dates of service <b>No</b>		16b SOCIAL SECURITY NO <b>579-58-3716</b>		17 INFORMANT <b>St., Nantuckett</b> Address <b>Mass.</b> <b>Mrs. Izetta W. Anderson, Off Lower Orange</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4</b> DUE TO, OR AS A CONSEQUENCE OF (Condition, if any, which gave rise to immediate cause (a) stating the underlying cause last <b>422</b> ) (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Status Post-resection small intestine</b>									
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>9</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY) (OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (this hospital) attended the deceased from <b>July 29 1968</b> to <b>Aug. 6 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug. 6 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (do not) view the body after death									
22b SIGNATURE <b>Eugene A. Kaplan, M.D.</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED <b>7 Aug. 1968</b>			
22d PHYSICIAN'S NAME (Type) <b>Eugene A. Kaplan</b>				22e ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a BURIAL, CREMATION, REMOVAL, ETC. <b>Burial</b>		23b DATE <b>8-9-1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>			
24 FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b>				25a REC'D BY REGISTRAR <b>5130 Wisconsin Ave., N.W., Washington, D. C.</b>		25b REGISTRAR'S SIGNATURE <b>John J. Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-105 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

11785

DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11793

DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH Month Day Year		2b H.C. #
Alma		P		Maynard	Aug 7 1968		68
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE in years (last birthday)	7a MONTHS	7b DAYS	7c HOURS	7d MIN
Female	W	9/16/86	81 YRS				
7a BIRTHPLACE (State or Foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Tenn.		U.S.A.				Montgomery	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a SOCIAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban		Housewife			
13a SOCIAL RESIDENCE (Where deceased lived, admissionary STATE)		13b COUNTY		13c STREET AND NUMBER			
Md.		Prince George's		2502 Allison St.			
4 FATHER'S NAME		5 MOTHER'S M.A.DEN NAME					
George		Georgina					
6a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		6b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
		579-05-7440		Alma Rabotin		Huntville Rd. Ala.	
8 CAUSE OF DEATH (Enter only one cause per line for a), b), and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE a) <u>Acute Congestive Heart Failure -</u> b) <u>Pneumonia Rt Lung -</u> c) <u>Arterio Sclerotic Heart Disease -</u> DUE TO, OR AS A CONSEQUENCE OF 2-1X (Conditions, if any, which gave rise to immediate cause, a), stating the underlying cause) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Fracture of Left Hip</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours 2 weeks years.
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20 AUTOPSY?			
6/18/68		Fracture of Left Hip - Nailed.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year		22 HOW INJURY OCCURRED (Enter nature of injury in Part 2 a) Part 2 item B)			
		6/13/68		Fall at home causing fracture of Left Hip.			
23 INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		23a PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		23b LOCATION Street or R.F.D. No. City or Town County State			
		Home		2502 Allison St Prince George's Md			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
John G. Ball		John G. Ball				Aug. 7, 1968	
23a BURIAL OR CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION City or Town County State	
removal		8/9/68		Mt. Olivet Cemetery		Nashville, Tenn.	
24 FUNERAL DIRECTOR The S.H. Hines Company				25a RT G BY R.C. CLAR		25b RIGHT OF INTERMENT	
2901 14th St. N.W. Wash. D.C.				DATE AUG 12 1968		John G. Ball	



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director to FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial or transit permit. Then please remove carbon papers, pages 1 and 2 and send them with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
11788									
794									
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. LENGTH OF STAY IN TB				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8600 16th St., Apt. 916</u>					d. STREET ADDRESS <u>8600 16th St., Apt. 916</u>				
3 NAME OF DECEASED Type or print: <u>MARY ELIZABETH McANDREW</u>					4 DATE OF DEATH Month <u>AUG</u> Day <u>29</u> Year <u>1968</u>				
5 SEX <u>F</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>12/6/03</u>		9 AGE in years last birthday <u>64</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary - U.S. Government</u>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13 FATHER'S NAME <u>Patrick McAndrew</u>					14 MOTHER'S MAIDEN NAME <u>Anna McNally</u>				
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16 SOCIAL SECURITY NO.		17 INFORMANT Address <u>Fred J. Neuland, Attorney 5101 River Road Bethesda, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCT</u>									
4100 DUE TO <u>CORONARY ARTERY DISEASE</u>									
Conditions of any which gave rise to immediate cause (a) stating the underlying cause last: <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8.)									
20c. TIME OF INJURY Month <u>Aug</u> Day <u>29</u> Year <u>1968</u> 20d. INJURY OCCURRED									
20e. PLACE OF INJURY Home farm <input type="checkbox"/> 20f. (City or town, County, State) <u>Hyde Park, Mass.</u>									
21 I certify that (I) (this hospital) attended the deceased from <u>4/1/68</u> to <u>8/29/68</u> that (I) we saw the deceased alive on <u>8/29/68</u> and that death occurred on <u>8/29/68</u> M from the causes and on the date stated above									
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYSICIAN									
22b. ADDRESS <u>4101 Linden Ave New York</u>									
22c. PHYSICIAN'S NAME (Type) <u>DR. D. GOLDENBERG</u>									
23a. BURIAL OR CREMATION REMOVAL (Specify) <u>Removal</u>									
23b. DATE THEREOF <u>9/1/68</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Grainview Cemetery</u>									
23d. LOCATION (City, town, or county State) <u>Hyde Park, Mass.</u>									
24 FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>2901 14th St. N.W. Wash. D.C.</u>									
25a. RECEIVED BY REGISTAR <u>SEP 3 1968</u>									
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. Permit 1 file pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and on any event within 72 hours after death.

11787

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <b>LEAH</b>		First <b>H.</b> Middle <b>MC</b> Last <b>CARTHY</b>		2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>		2b HOJR 15	
3 SEX <b>Female</b>	4 RACE <b>W</b>	5 DATE OF BIRTH <b>7/22/17</b>	6 AGE in years MONTHS <b>51</b> YEARS <b>51</b>	IF UNDER 24 HRS MONTHS <b>51</b> DAYS <b>51</b> HOURS <b>51</b> MIN <b>51</b>	2c DATE PROMULGATED DEAD Month <b>8</b> Day <b>6</b> Year <b>1968</b>		2d HOJR <b>15</b>
7a BIRTHPLACE (State or foreign country) <b>W.Va.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>	
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		NAME OF HOSPITAL OR INSTITUTE, OR IF NOT IN HOSPITAL (give street address) <b>Holy Cross Hospital</b>		2a USUAL OCCUPATION Kind of work done during most of working life, even if retired. <b>Housewife</b>		2b KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
3a SOCIAL RESIDENCE (Where deceased lived + institution Residence before admission) STATE <b>Md</b>		3b COUNTY <b>Montg.</b>		3c STREET AND NUMBER <b>11514 Bucknell Dr.</b>		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4 FATHER'S NAME First <b>Ruthen</b> Middle <b>Dunn</b> Last <b>Lee</b>		5 MOTHER'S MAIDEN NAME First <b>Helen</b> Middle <b>XXXXXXX</b> Last <b>Lee</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Not Known) <b>No</b>		17 INFORMANT <b>Joseph J. McCarty</b>	
18 CAUSE OF DEATH Enter only one cause per line (a) or (b) and PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure due to Barbiturate Intoxication, self administered</b>		(b) <b>admitted</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Depression</b>							
9a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month Day Year <b>11:00 PM 7-24-68</b>		2c HOW INJURY OCCURRED Enter nature of injury in Part 2 or Part 2, Item 81 <b>Deceased, depressed, took overdose of barbiturates</b>			
2d INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>		2e PLACE OF INJURY At home farm street factory other building etc. <b>HOME</b>		2f LOCATION Street if RFD No. City or town County State <b>11514 BUCKNELL DR. Wheaton Montgomery Md.</b>			
22a I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Keap</b>		22b DATE SIGNED <b>Aug. 6, 1968</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME Type <b>BELDEN R. KEAP, M.D.</b>		23b DATE <b>Aug. 6, 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>West Lincoln Crematory</b>		23d LOCATION City or Town County State <b>Prince Georges Co. Md.</b>	
23a BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>		23b DATE <b>Aug. 6, 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>West Lincoln Crematory</b>		23d LOCATION City or Town County State <b>Prince Georges Co. Md.</b>	
24 FUNERAL DIRECTOR <b>Charles E. Humphrey</b>		24b DATE <b>Aug. 6, 1968</b>		24c NAME OF CEMETERY OR CREMATORY <b>West Lincoln Crematory</b>		24d LOCATION City or Town County State <b>Prince Georges Co. Md.</b>	

[ ]

10



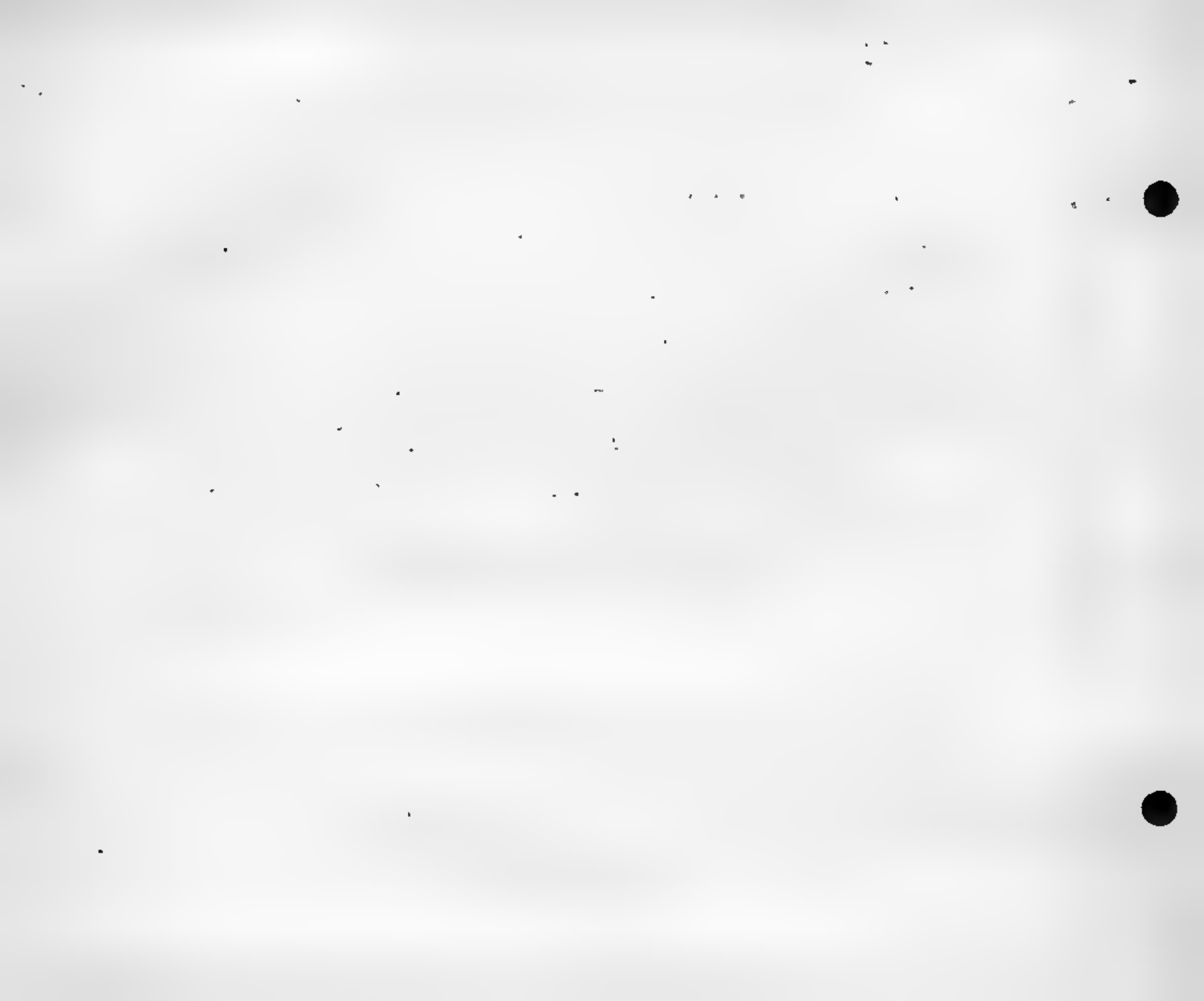
11783

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <sup>First</sup> Lake <sup>Middle</sup> William <sup>Last</sup> McCrossin			2a. DATE OF DEATH Aug 25, 1968		2b. HOUR 4:30 PM
3 SEX Male	4 RACE White	5. DATE OF BIRTH 8/9/1914	6 AGE in years (last day) 54	7 UNDER 1 YEAR MONTHS	8 UNDER 24 HR. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Potomac		11 NAME OF HOSPITAL OR INSTITUTION, (if not in hospital give address) 11001 Brent Road		2a. U.S.A. OCCUPATION Kind of work done during last week before death Government Emp.	
3a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		3b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13a. STREET AND NUMBER 11001 Brent Road
14 FATHER'S NAME <sup>First</sup> Elzy <sup>Middle</sup> <sup>Last</sup> McCrossin		5 MOTHER'S M A D E N NAME <sup>First</sup> Clara <sup>Middle</sup> <sup>Last</sup> Hill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) Yes		16b. SOCIAL SECURITY NO. WW LL 218-12-2383	17 INFORMANT Ethel J. McCrossin - wife - same item		
8. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of left kidney</u> 1890 DUE TO, OR AS A CONSEQUENCE OF <u>with wide spread metastases</u> Conditions (any which gave rise to immediate cause (a) stating the underlying cause last) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 mo					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1, a. 170X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 7-2-54 to 8-25-68, that (I) (we) last saw the deceased alive on 8-25-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death					
22b. SIGNATURE Charles P Ryland		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED 8-25-68	
22d. PHYSICIAN'S NAME (Type) CHARLES P RYLAND		22e. ADDRESS 4400-49th NW, Washington			
23a. BURIAL CREMATION Buried		23b. DATE 8/28/68		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
23d. LOCATION (City or Town) Rockville, Maryland		23e. LOCATION (County) (State)			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rockville		ADDRESS Rockville, Maryland		25a. REC'D BY REGISTRAR Pik AUG 27 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and a copy event within 72 hours after death.



**HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA 5-14  
304 REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1178A

11797

DECEASED NAME (Type or print) First Middle Last <b>Ronald Anthony McDaniel</b>			20. DATE OF DEATH Month Day Year <b>August 19 1968</b>			26 HOUR AM <b>12:30 AM</b>		
3 SEX <b>Male</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH <b>14 November 1953</b>		6 AGE in years lost birthday, YRS <b>14</b>		
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Montgomery</b>		
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11 NAME OF HOSPITAL OR INSTITUTION (not in hospital give street address) <b>The Clinical Center, NIH</b>		20 US & AL OCCUPATION (Kind of work done during most of working life even if retired) <b>Student</b>		17b KIND OF BUSINESS OR INDUSTRY <b>--</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>New Jersey</b>			13c CITY OR TOWN <b>Atlantic City</b>		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e STREET AND NUMBER <b>3 Raynor Terrace</b>	
4 FATHER'S NAME First Middle Last <b>John McDaniel</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Clementine Moses</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>No</b>			16b SOC. SEC. ID. NO. <b>None</b>		17 INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Md. 20014</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a) (b) and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage with Encephalomalacia</b> 2040 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Lymphocytic Leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 Days</b> <b>2 Months</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
9a DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If neither, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 8)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (A) (this hospital) attended the deceased from <b>June 17 1968</b> to <b>August 19 1968</b> , that (X) (we) lost saw the deceased alive on <b>August 19 1968</b> , and that in (P) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death								
22b. SIGNATURE <b>David H. Riddick, MD</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>19 August 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>David H. Riddick, MD</b>				22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				
23a. BURIAL OR CREMATION Removal Specified <b>Burial</b>		23b. DATE <b>8-20-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Pleasantville N.J.</b>		
24. FUNERAL DIRECTOR <b>W.W. Chamber C 1400 Chapin St NW</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MEDICAL CERTIFICATE



11700

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
George		M	McILHENNY	McILHENNY	Aug 14 1968		2:30 PM		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 24 HRS		
MALE	WHITE		10/15/05		62 YRS		11 29		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
TEXAS		U.S.A.				MONTGOMERY Md			
10 CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		2a USUAL OCCUPATION Kind of work done during most of working life, even if retired.		12b KIND OF BUSINESS OR INDUSTRY			
BETHESDA		SUBURBAN		COST ACCT		Handicapped Supply			
13a USUAL RESIDENCE (Where deceased lived if not in hospital give street address)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND		Montgomery		Kensington				10355 Greenfield St.	
4 FATHER'S NAME		5 MOTHER'S MAIDEN NAME							
Isabel F		Mary Franklin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give unit or dates of service)		16b SOCIAL SECURITY NO		7 INFORMANT Address					
No		455-05-0791		EDNA H MCILHENNY - WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage, massive, nasopharyngeal									
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma, larynx status post irradiation									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)									
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		2 HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18.)					
21c INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21d PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from 19 to 8-14, 1968 that (1) (we) lost the deceased alive on 8-14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death									
22b. SIGNATURE V.C. DeGuzman MD								22c. DATE SIGNED 8/16/68	
22d. PHYSICIAN'S NAME (Type) V.C. DeGuzman M.D.								22e ADDRESS 8512 Old Georgetown Rd. Beth. Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		8/17/68		Parklawn Cem.		Rockville Montg. Md.			
24. FUNERAL DIRECTOR Robert A. Pumphrey 7557 Wisconsin Ave. Bethesda, Md.				25a. REC'D BY REGISTRAR DATE AUG 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



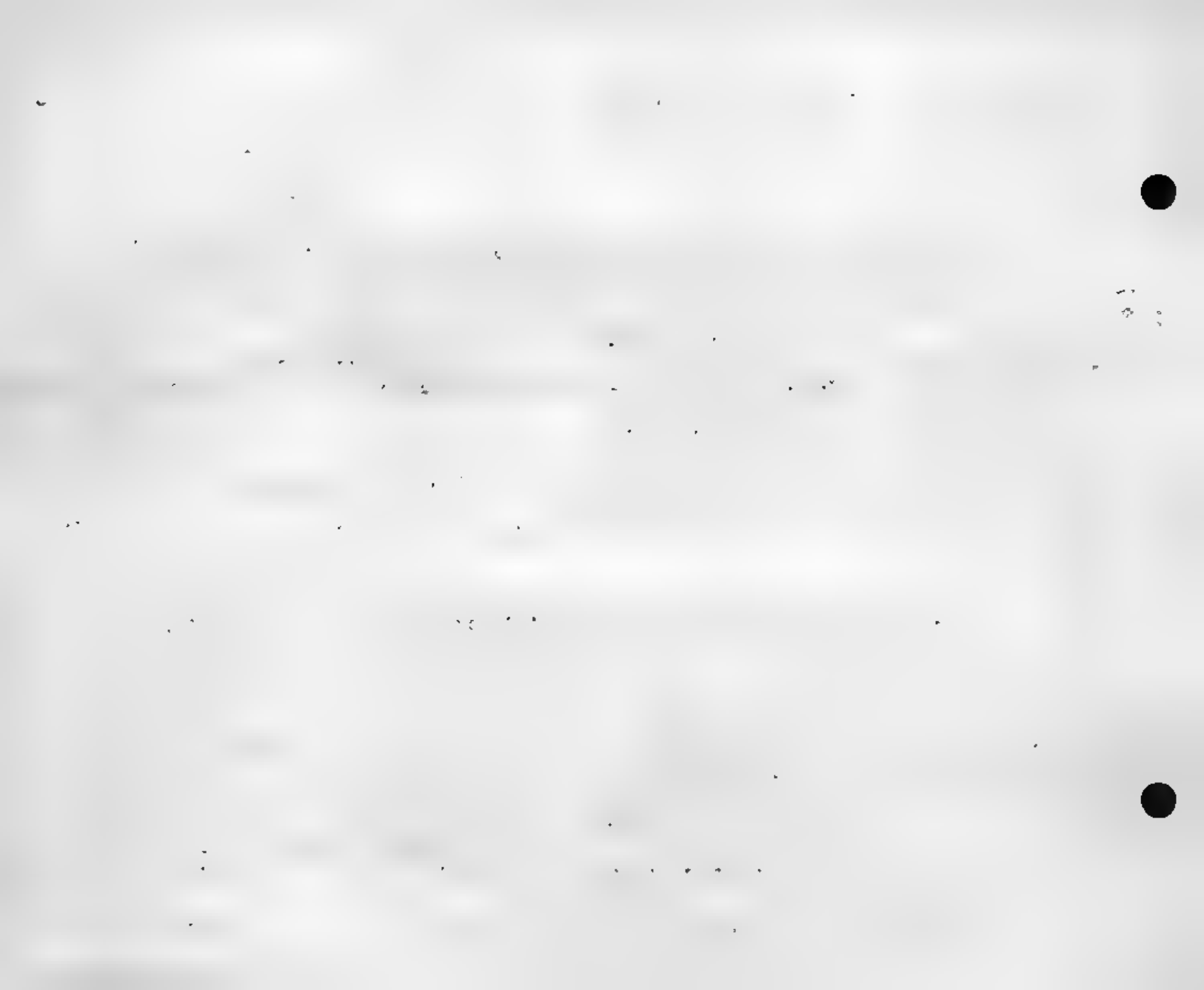
TO HOSPITAL ■■■ ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then, please remove carbon papers, pages 1 and 2, and return them to the funeral director. The original certificate should be filed with the State Dept. of Health prior to burial or cremation, or removal and in any event, within 72 hours after death.

VR A 5 (4)  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11799									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR JRM	
Luther Junior McQuain						Month Day Year August 9 1968		9:05 M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE, in years (age at birthday)		7 IF UNDER 1 YEAR	
Male		White		16 June 1927		41 YRS		MONTHS DAYS HOUR MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
West Virginia		USA				Montgomery Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		The Clinical Center, NIH		Teacher		Education			
3a USAL RESIDENCE (Where deceased lived, if institution Residence before admission)			3b CITY OR TOWN		3c INSIDE CITY LIMITS?		13a STREET AND NUMBER		
Virginia			Falls Church		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2914 Monroe Place		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Allen Luther McQuain			Appie Lantz						
6a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT The Medical Record Address				
Yes 1945-1946			235-30-2354		The Clinical Center, NIH, Bethesda, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia								36 Hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Flaccid Coma following open heart surgery								17 Days	
DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic Valvular Heart Disease								23 Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I, a)									
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a ALTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
7/23/68		Mitral Stenosis & Insufficiency			NO <input type="checkbox"/>		Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
		19							
22a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21c LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (th's hospital) attended the deceased from 15 July 1968 to 9 August 1968, that (I) (we) last saw the deceased alive on 9 August 1968, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Ronald M. Abel, M. D.						10 August 1968			
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS			22f REGISTRAR'S SIGNATURE				
Ronald M. Abel, M. D.		The Clinical Center, National Institutes of Health, Bethesda, Maryland							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23 NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town (County) (State)			
Burial		Aug 12, 1968		National em. Park		Falls Church, Va			
24 FUNERAL DIRECTOR		24b ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Pearson's Funeral Home		Falls Church, Va		DATE AUG 14 1968		Charles Judge			

MEDICAL CERTIFICATE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11792

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
1000 736 Film 61-1000  
**CERTIFICATE OF DEATH**

800

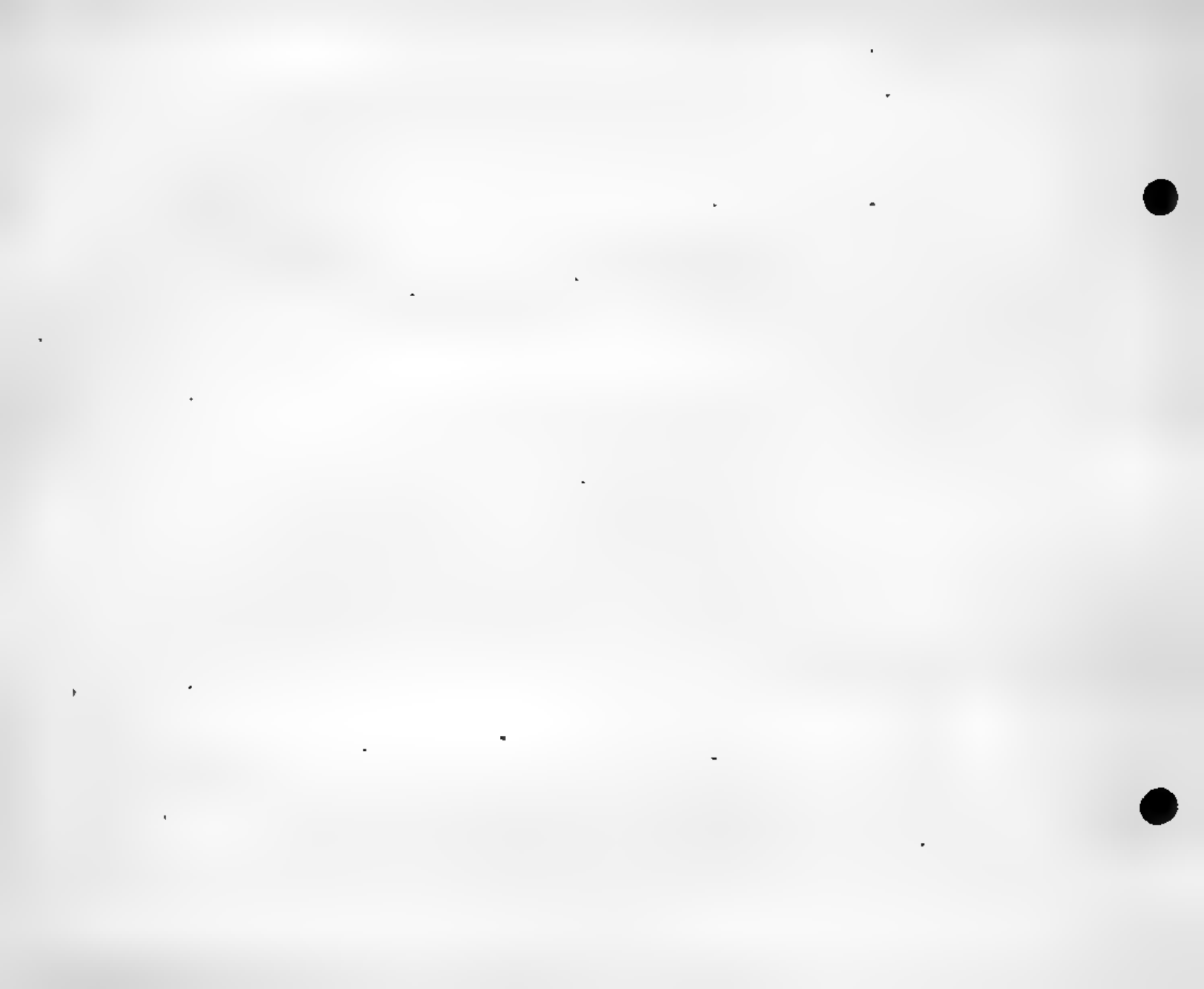
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
John		William	Megginsin, Jr.		August 20 1968		10:30	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE in years last birthday		7 IF UNDER 1 YEAR MONTHS DAYS HRS	
Male	White		12 January 1928		40 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Virginia		USA				Montgomery		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS, OR INDUSTRY		
Bethesda		The Clinical Center		Salesman				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Virginia		Campbell		Lynchburg				4524 Greenwood Drive
14 FATHER'S NAME		First	Middle	Last	5. MOTHER'S MAIDEN NAME		First	Middle
John		W.	Megginsin, Sr.		Mamie			Currier
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name, unknown)		16b. SOCIAL SECURITY NO		7 INFORMANT The Medical Record Address				
No		227-22-9623		The Clinical Center, NIH, Bethesda, Md. 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest 1000 DUE TO, OR AS A CONSEQUENCE OF (b) Embryonal cell - carcinoma of testicle Conditions: Tumor which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 8 months								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from 11 August 1968 to 20 August 1968 that (2) (we) lost saw the deceased alive on 20 August 1968, and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) (did) (did not) view the body after death								
22b. SIGNATURE Gerson N. Kaplan, MD				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 21 August 1968		
22d. PHYSICIAN'S NAME (Type) Gerson N. Kaplan, M. D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Aug. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft. Hill Mem. Park		23d. LOCATION City or Town (County) (State) Lynchburg, Virginia		
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.				25a. REC'D BY REGISTRAR DATE AUG 23 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
11793											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH		
SIMON							MICHNICK		Month Day Year 1968 5:15 PM		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE in years		7 MONTHS		
Male		Caucasian		12/24/1918			49 YRS		8 UNDER 24 HRS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 NEVER MARRIED		9 COUNTY OF DEATH			
New York		U.S.A.		WIDOWED		DIVORCED		Montgomery			
10 CITY OR TOWN OF DEATH			NAME OF HOSPITAL OR INSTITUTION, if not in hospital give street address			2a OCCUPATION (Kind of work done during most of working life, even if retired)			2b KIND OF BUSINESS OR INDUSTRY		
Silver Spring			9312 Greyrock Rd.			Builder					
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		3c CITY OR TOWN		3d RESIDENCE (Type of home)		13e STREET AND NUMBER		
Maryland			Montgomery		Silver Spring		YES		9312 Greyrock Rd.		
4 FATHER'S NAME			5 MOTHER'S MAIDEN NAME								
Abraham Michnick			Celia Kravitz								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			18 ADDRESS		
unknown						Howard Michnick			1812 K St., N.W. Washington, D.C.		
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pericardial Pneumonia										6 d.	
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma										5 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Prostate										5 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES		NO			
21a ACCIDENT WAS UNDERLYING			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year								
22a INJURY OCCURRED			22b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			22c LOCATION Street or R.F.D. No City or Town County State					
While at work											
22a I certify that (I) (the hospital) attended the deceased from Nov. 1963, to Aug. 1, 1968, that (I) (we) lost saw the deceased alive on 8/1/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b SIGNATURE			22c DEGREE			22d ADDRESS			22e DATE SIGNED		
Samuel Diener, M.D.			DEGREE			4201 MASS. AVE. N.W. WASH., D.C.			8/1/68		
22d PHYSICIAN'S NAME (Type)			22e ADDRESS								
DR. SAMUEL DIENER			4201 MASS. AVE. N.W. WASH., D.C.								
23a BURIAL CREMA. OR REMOVAL Specify			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			8/4/68			King David Mem. Garden			Falls Church, Va.		
24 FUNERAL DIRECTOR			24a ADDRESS			24b REC'D BY REGISTRAR			24c REGISTRAR'S SIGNATURE		
Bernard Danzansky & Sons			3501 14th St. N.W. Washington, D.C.			DATE AUG 6 1968			J. Charles Judge		



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last <b>MURDERED M MILLER</b>						2a. DATE OF DEATH Month Day Year <b>August 26 1968</b>			2b. HOUR <b>3:00 A.M.</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>4/4/1908</b>		6 AGE (in years last birthday) <b>60</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS <b>90 90 90</b>		IF UNDER 24 HRS HOURS MINUTES <b>90 90</b>	
7a. BIRTHPLACE (State or foreign country) <b>LITHO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>MONTGOMERY Co.</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring, Md.</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp.</b>				2a. SOCIAL OCCUPATION (Kind of work done during most of working life even if retired) <b>At Home</b>		12b. KIND OF BUSINESS OR INDUSTRY	
3a. SOCIAL RESIDENCE (Where deceased lived, if institution Residence before admission, STATE <b>md.</b>				3c. CITY OR TOWN <b>Montgomery</b>		3d. RESIDENCE CITY, STATE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET AND NUMBER <b>EAST-WEST BLVD.</b>			
14 FATHER'S NAME First Middle Last <b>MORRIS MASON</b>				15 MOTHER'S M.A.D.E.N. NAME First Middle Last <b>UNKNOWN</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>			
16b. SOCIAL SECURITY NO. <b>—</b>				17. INFORMANT <b>Charles T. Miller</b>				Address <b>Queen Mary Dr 3909 Olney, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute left ventricular heart failure</b> 2 hours											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic hypertensive heart disease</b> years											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Deep lacerations (2) Gastrointestinal bleeding of undetermined site</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If e the nearly medical examiner)		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year <b>8-20 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State <b>8-20 1968 to 8-26 1968</b>		22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>8-26 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jason G. Baker, M.D.</b>		22c. PHYSICIAN'S NAME (Last) <b>JASON G. BAKER, M.D.</b>		22d. ADDRESS <b>800 PERSHING DRIVE SILVER SPRING, MD</b>		22e. DATE SIGNED <b>8-26-68</b>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL CREMATION (Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> )		23b. DATE <b>8-28-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Anshe Dwig Cemetery, West Roxbury, Mass.</b>		23d. LOCATION (City or Town) (County) (State) <b>West Roxbury, Mass.</b>		23e. REC'D BY REG. STRIP <b>AUG 28 1968</b>			
24. FUNERAL DIRECTOR <b>Elkworth Remcast</b>		ADDRESS <b>4600 Liberty Heights Ave</b>		24b. SIGNATURE <b>Charles Judge</b>		24c. DATE <b>AUG 28 1968</b>					



11795

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

803

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit for pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print) <b>Lyman Winfield Mitchell</b>			2a. DATE KNOWN OF DEATH Month <b>Aug</b> Day <b>3</b> Year <b>1968</b>			2b. HOUR OF DEATH Hour <b>2:30</b> Minute <b>PM</b>		
3 SEX <b>M.</b>	4 RACE <b>W.</b>	5 DATE OF BIRTH <b>April 27/1878</b>	6 AGE at death <b>90</b> YRS	7a. IF UNDER 1 YEAR MONTHS DAYS	7b. IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month <b>Aug</b> Day <b>3</b> Year <b>1968</b>		2d. HOUR Hour <b>2:30</b> Minute <b>PM</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Garthersburg</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Asbury Methodist Home</b>		12a. US A1 OCCUPATION (Kind of work done during past 12 months) (working, retired, etc.) <b>Shipping Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. LAST RESIDENCE (Where deceased lived at time of admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>724 Grantly Street</b>
14. FATHER'S NAME First <b>Thomas</b> Middle <b>W.</b> Last <b>Mitchell</b>			15. MOTHER'S MAIDEN NAME First <b>Isabella</b> Middle <b>Wolfe</b> Last <b>Wolfe</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No.</b>			16b. SOCIAL SECURITY NO. <b>No.</b>			17. INFORMANT <b>Asbury Methodist Home Garthersburg.</b>		
18. CAUSE OF DEATH (Enter on only one cause per line for a, b, and c.) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE a. <b>Coronary Insufficiency Acute</b> DUE TO OR AS A CONSEQUENCE OF Conditions if any which gave rise to immediate cause of death stating the underlying cause last <b>Cardio Vascular Disease</b> DUE TO OR AS A CONSEQUENCE OF (c) <b>Sudden</b> years								APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>42</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John S. Ball</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>August 3, 1968</b>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
			ADDRESS (Street, city, town, or county)					
23a. B.R.A. CREMATION PERMITS TYPE <b>Burial</b>		23b. DATE <b>8/6/68</b>		23c. NAME OF CEMETERY OR REMATORY <b>Louder Park</b>		23d. LOCATION City or Town (County) State <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Wm. J. Tichner Sons Baltimore, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The now requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

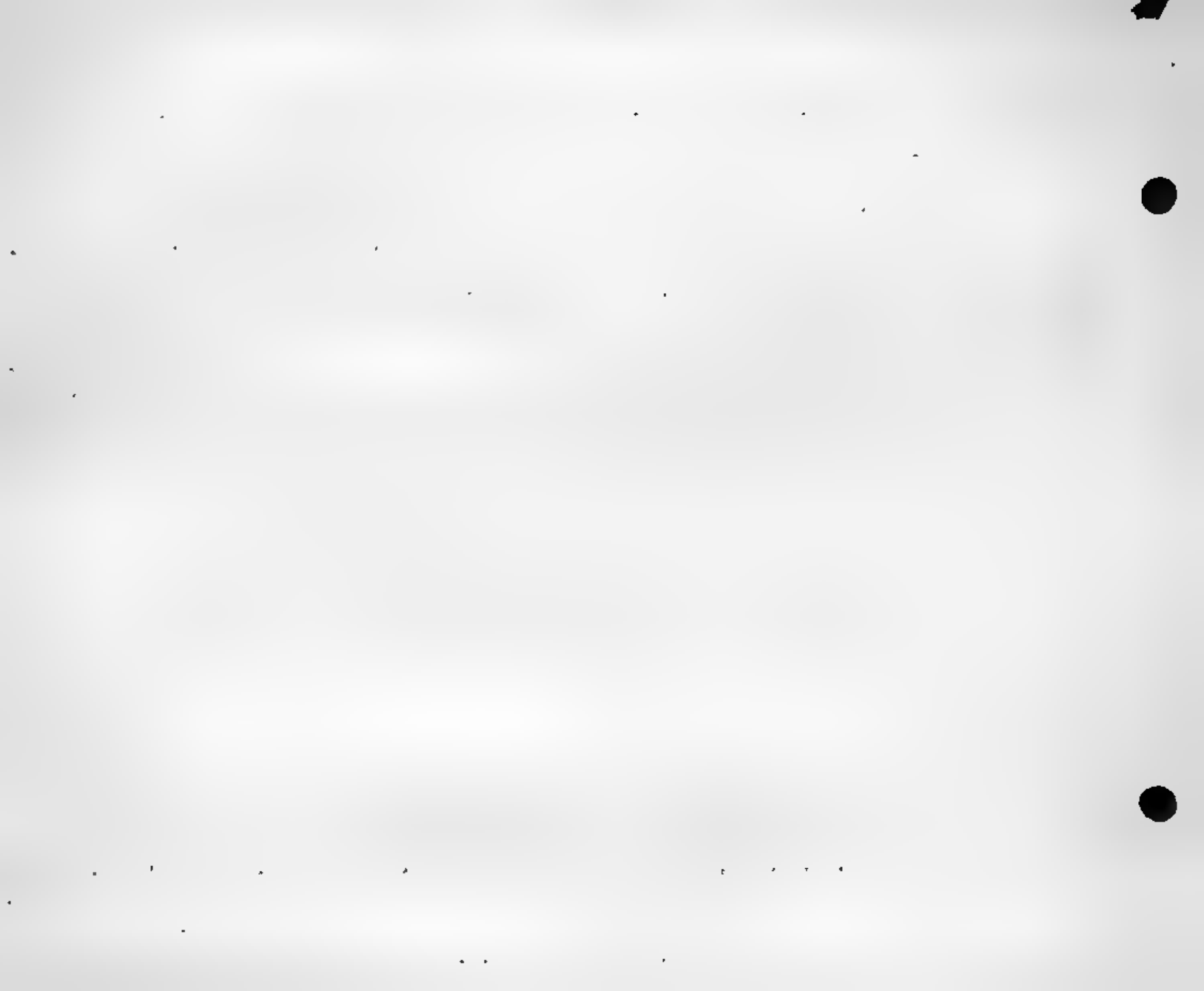
VR 15-1  
3044 REV. 1-7-56

11790

DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

804

DECEASED NAME (Type or print) First Middle Last RAYMOND C. McFETT			2a. DATE OF DEATH Month Day Year Aug. 23, 1968			2b. HOUR P. 4:10 M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 4-6-19-2		6. AGE in years (if 60th birthday) 68 YRS.	
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3612 Dunlap Street		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Asst. Treas.-retired		12b. KIND OF BUSINESS OR INDUSTRY C. & P.Tel.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSURE BY UNITS YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3612 Dunlap Street		14. FATHER'S NAME First Middle Last Jacob Thomas Moffett		15. MOTHER'S MAIDEN NAME First Middle Last Lillian Reich			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If give year or dates of service) no		16b. SOCIAL SECURITY NO. 577-01-2814		17. INFORMANT Tom Moffett, Son, 6805 Butternut La., Beth.		Address Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis & Vent. F. b. DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS (any which gave rise to immediate cause (a), stating the underlying cause last)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If neither, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
22a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		22b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		22c. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7/29 1968 to 8/23 1968 that (I) (we) last saw the deceased alive on 8/23 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (a) (did not) view the body after death							
22b. SIGNATURE W. D. Joyce, MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8-24-1968	
22d. PHYSICIAN'S NAME (Type) W. D. Joyce, MD				22e. ADDRESS 4977 Battery Lane, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-27-1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery Silver Spring, Montgomery Co.		23d. LOCATION (City or Town) (County) (State) Montgomery Co.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. Washington, D.C.				25a. REC'D BY REGISTRAR DATE AUG 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The now requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

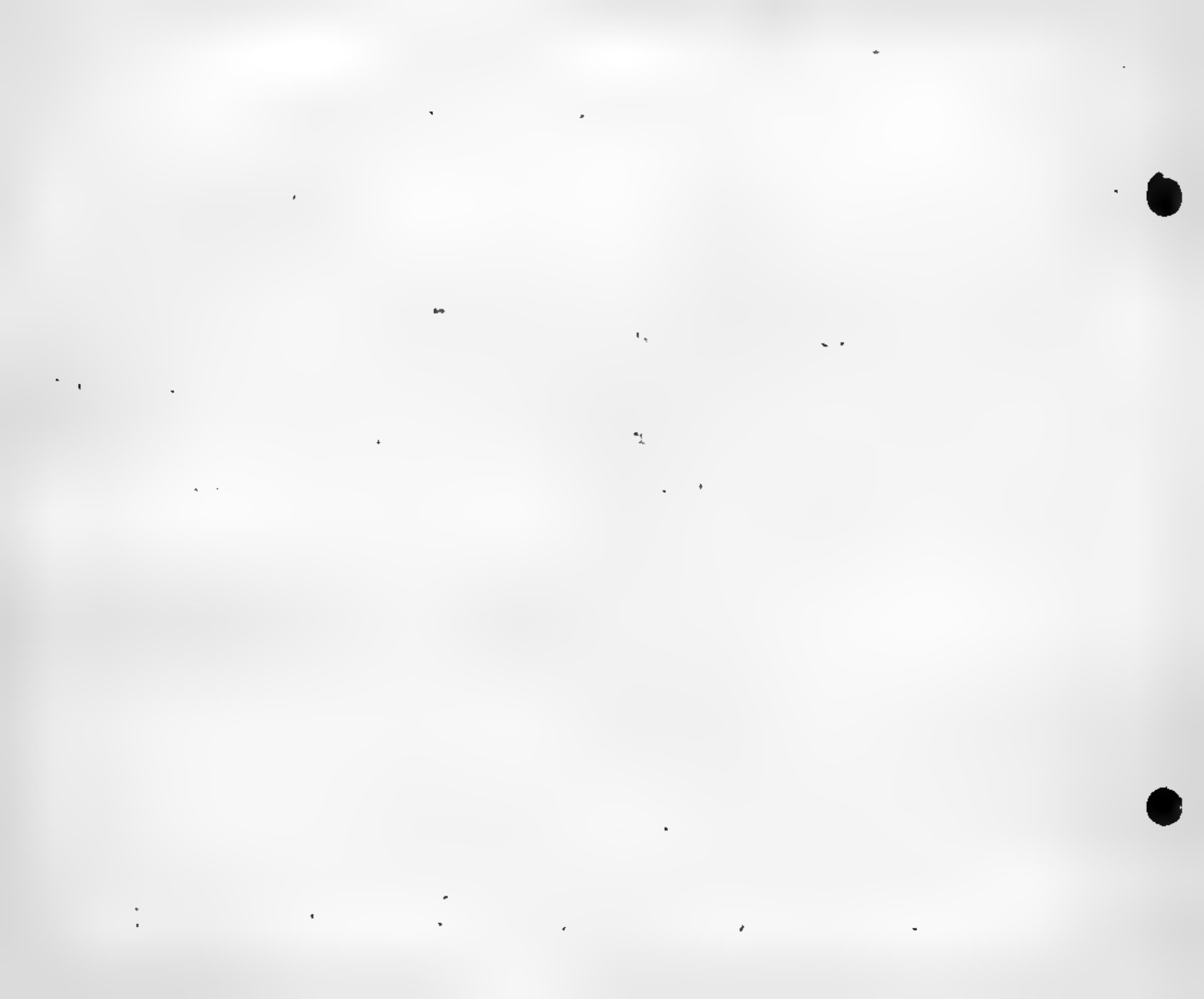
MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
11797			DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
			ESTELLE TYSON MOORE						AUGUST 4 1968		5:57 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
Female		White		August 25, 1890			77 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Maryland			U. S. of A.						Montgomery County, Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Olney			Montgomery General Hospital			Searstress						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			3b. COUNTY			3c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery			Sandy Spring			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S M maiden name			First Middle Last						
Joseph T. MOORE			Estelle TYSON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> If yes give war or dates of service			16b. SOCIAL SECURITY NO			17. INFORMANT			Address			
NO			216-342276			HOSP & RECORDS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO OR AS A CONSEQUENCE OF <u>Chorea</u> (b) <u>Chronic blood pyelonephritis</u> DUE TO OR AS A CONSEQUENCE OF <u>Chorea</u> (c) <u>Chorea</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 wk</u> <u>1 yr</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. A. TOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> If either notify medical examiner.			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 9			21c. HOW INJURY OCCURRED (Enter nature of injury in Part or Part 2 Item B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (A HOME, FARM, STREET, DRIVE, BUILDING, ETC. ACTIVITY)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (i) (this hospital) attended the deceased from <u>Aug 4</u> , 19 <u>50</u> , to <u>8/4</u> , 19 <u>68</u> , that (i) (we) last saw the deceased alive on <u>Aug 4</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we), (did) (did not) view the body after death												
22b. SIGNATURE			22c. DEGREE			22d. ADDRESS			22e. DATE SIGNED			
<u>C.H. Wilson MD</u>			<u>MD</u>			<u>SANDY SPRING MD</u>			<u>8/5/68</u>			
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
<u>BURIAL</u>			<u>Aug 7, 1968</u>			<u>FRIENDS MEETING</u>			<u>SANDY SPRING MOUNT. MD</u>			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
<u>Francis H. Barber, Sandy Spring Md.</u>			<u>AUG 9 1968</u>			<u>Charles Judge</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no any event within 72 hours after death.

11793		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH				1806				
1 DECEASED NAME (Type or print)				First	Middle	Last	2a DATE OF DEATH Month Day Year				2b HOUR Hour Minute			
HENRY				CULVER	MORGAN	August 6 1968				11:40 AM				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 JUNIOR YEAR		8 JUNIOR DAY		9 JUNIOR HOUR		
MALE		CAU		SEPT. 25 1905		42 YRS		MONTHS		DAYS		HOURS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH								
N.Y.		U.S.A.				MONTGOMERY Md.								
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a U.S.A. OCCUPATION Kind of work done during most of working life, even if retired.				12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring, Md				Holy Cross Hosp				SALES MAN				H. KOHN, SALES MAN		
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INHABIT CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER				
Maryland				Montgomery		Silver Spring				10304 Ridgeview Dr.				
14 FATHER'S NAME First Middle Last				15 MOTHER'S M A DEN NAME First Middle Last										
HENRY P. MORGAN				MARY — WH. APPLE										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates or service)				16b SOCIAL SECURITY NO		17 INFORMANT Address								
No				337-07-1311		ALICE F. MORGAN - SAME AS #13								
18. CAUSE OF DEATH (Enter only one cause per line for a, (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1959												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF metastases to L lung, liver & L adrenal												15 months		
DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) hydrothorax, bilateral														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If not natly medic examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 39				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home farm street factory office building etc)				21f. LOCATION Street or R.F.D. No City or Town County State						
22a I certify that (I) (this hospital) attended the deceased from Mar 1927 to Aug 6, 1968 that (I) (we) lost the deceased alive on Aug 5 1968, and that in (my) (our) opin on death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE				22c. DATE SIGNED										
Samuel T. Kimble, M.D. DEGREE				Aug 6, 1968										
22d. PHYSICIAN'S NAME (Type) Seruch T. Kimble				22e. ADDRESS										
				9801 Ridgeway Ave, Silver Spring, Md										
23a. BURIAL CREMATION, REMOVAL Specify				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION City or Town County State				
CREMATION				8/7/68		CEDAR HILL CREM.				SUITLAND, MD.				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
JOS. SAWLER'S SONS				DATE AUG 9 1968				Charles Judge						

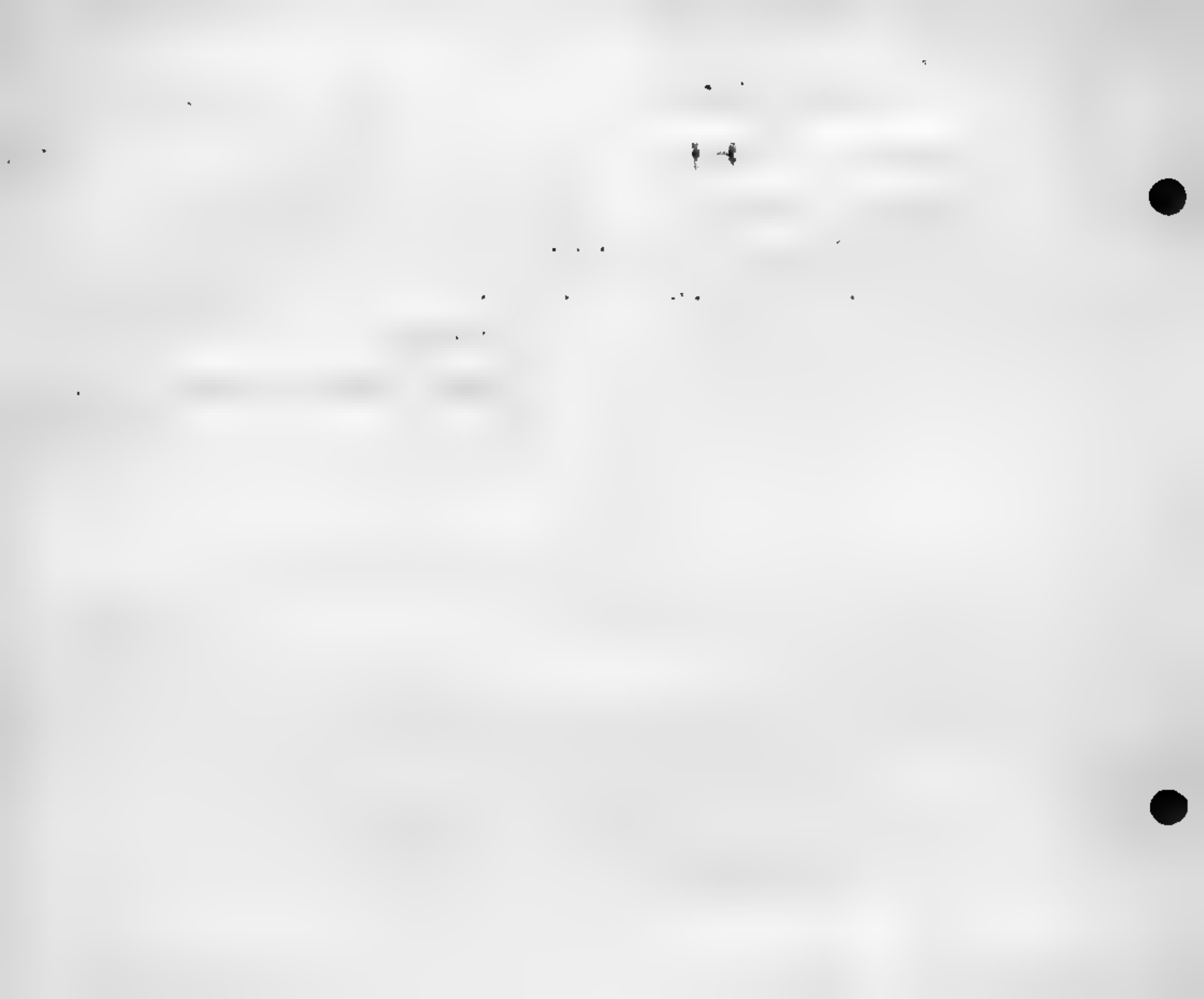


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 28. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 in the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			2a DATE KNOWN OF ESTI- MATED			2b HOUR			
MARGARET COLLINS MORLEY			8-7-68		19				
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	7 UNDER 1 YEAR	8 UNDER 1 YEAR	9 UNDER 1 YEAR	21 DATE PRONOUNCED DEAD		2d HOUR
Female	White	2-15-14	54 YRS	MONTHS	DATE	HOURS	MIN	Month 8 Day 7 Year 19 68	5:19
7c BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH			
Ireland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12 USUAL OCCUPATION Kind of work done during most of working life ever (retired)		2b KIND OF BUSINESS OR INDUSTRY			
Takoma Park		W.S.H.							
3a USUAL RESIDENCE Where deceased lived at institution: Residence before admission STATE		3b COUNTY		3c CITY OR TOWN		3d HOUSE CITY LIMIT		3e STREET AND NUMBER	
Md.		P.G.		W.Hyatts.		YES <input type="checkbox"/> NO <input type="checkbox"/>		6401 Elliott Place	
14 FATHER'S NAME First Middle Last				15 MOTHER'S M.A.D.E.N. NAME First Middle Last					
Timothy Collins				Bridget Lane					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS			
None						Margaret Morley, Same Address DTR.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fat embolism to lungs secondary to fall at home, fractured pelvis, and ethylism									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
94.									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month Day Year		21c HOW INJURY OCCURRED Enter nature of injury in Part 1 or Part 2 Item 18.			
				8-1 19 68		Deceased fell at home and fractured pelvis			
22a INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input checked="" type="checkbox"/> AT WORK		22b PLACE OF INJURY At home, farm, street, factory, office, building, etc.		22c LOCATION Street or R.F.D. No		City or Town		County	State
		Home		6401 Elliott Pl.		W.Hyattsville		F.G.	Md.
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME Type		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
Belden Reap, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		C. J. Jones, M.D.		Aug. 8, 1968	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		County	State
		8-12-68		Gate of Heaven		Gresham		Md.	
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Thomas B. Hanson 4748 W. Ascension Ave. W. U.				DATE AUG 20 1968		J. Charles Jones			

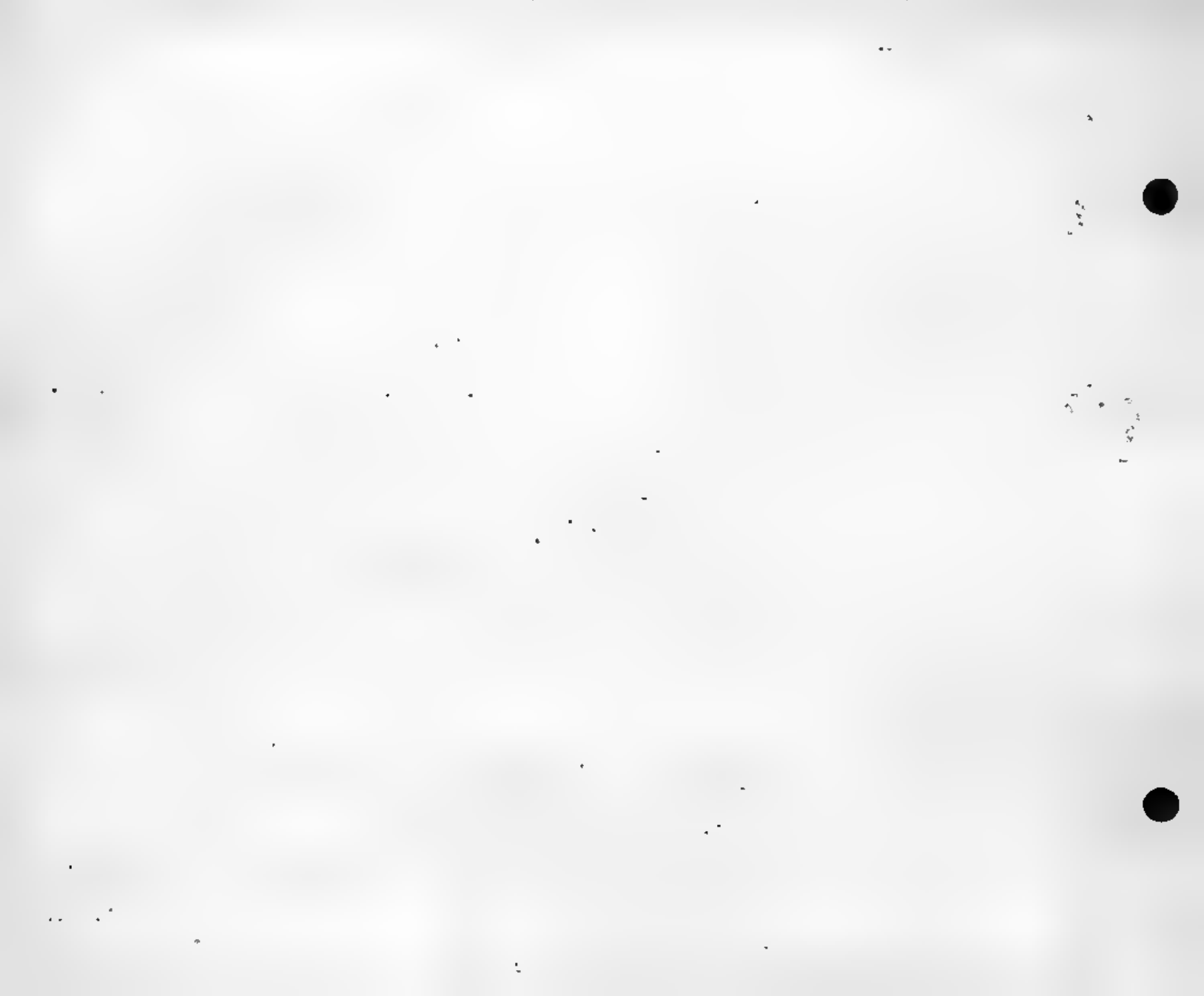




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11800 Item 11 Film G.0.0.1									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
Ward			Wooten			Month Aug Day 12th Year 68		12:30 A	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		June 1st 1907		61 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		U S A				Montgomery		Md.	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Gaithersburg			11a. Deem Avenue			Bondman			
13a USUAL RESIDENCE (Where deceased lived 1 institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS	
104 Deem Ave						Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last			5 MOTHER'S M A D E N NAME First Middle Last			13e STREET AND NUMBER			
Henry W. Mullican			Alice Ward			104 Deem Ave. Gaithersburg			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT Address			
						Estelle A. Mullican. 104 Deem Ave. Gaithersburg			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u>									on Heart
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ESSENTIAL HYPERTENSION</u>									25 years
DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>									25 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
<u>DIABETES MELLITUS</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
<input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year							
(If either, not by medical examiner)		P.M. 19							
22a. INJURY OCCURRED		22b. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)		21e. LOCATION Street or RFD No City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/>									
at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>April 17, 1968</u> to <u>April 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
<u>Ernest C. Gartner</u>						ATTENDING PHYSICIAN			
22d. PHYSICIAN'S NAME (Type, Print, or Stamp)						22e. ADDRESS			
Ernest C. Gartner						310 W. Montgomery		Gaithersburg, Md.	
23a. BURIAL CREMATION REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town, County, State)			
Burial		8-14-68		Forest Oak		Gaithersburg Montg. Md.			
24. FUNERAL DIRECTOR Ernest C. Gartner. ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Gaithersburg, Md.						DATE AUG 15 1968		<u>Charles Judge</u>	



1  
 11801  
 11809  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
 CERTIFICATE OF DEATH  
 1  
 47  
 3  
 2  
 1  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <b>Hazel C Musgrave</b>										2a. DATE OF DEATH Month <b>8</b> Day <b>19</b> Year <b>68</b>				2b. HOUR <b>8:30 P.M.</b>	
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>1-23-87</b>			6. AGE (In years last birthday) <b>81</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.						
10. CITY OR TOWN OF DEATH <b>Rockville, Md.</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Potomac Valley Nursing Home</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>						13b. COUNTY <b>N</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2412 10th Street, N.E.</b>			
14. FATHER'S NAME First <b>Samuel</b> Middle <b></b> Last <b>Ammon</b>			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Ann</b> Last <b>Mary</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>No</b> (If yes give war or dates of service)						16b. SOCIAL SECURITY NO. <b>you</b>		17. INFORMANT Address <b>Mrs. Edna Weisner 2415 Dexter Avenue, S.S., Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes mellitus</b>														30 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b>														20 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>260x</b>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>12-20, 1965</b> to <b>8/19, 1968</b> , that (I) (we) last saw the deceased alive on <b>5-1, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>W. G. Hall, MD.</b>				DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>8/19/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>W. G. Hall, MD.</b>				22e. ADDRESS <b>615 W. Montgomery Ave. Rockville, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>Aug. 23, 1968</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Chartiers Cemetery</b>				23d. LOCATION (City or Town) <b>Pittsburgh</b> (County) <b></b> (State) <b>Penna.</b>			
24. FUNERAL DIRECTOR <b>Walter E. Humphrey, Inc. 8434 Ga. Ave. S.S. Md.</b>				25a. REC'D BY REGISTRAR <b>AUG 23 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11806		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				11810	
Item 13 Film Quot. 8/20/68 R							
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last JANE TRAVERS MYERS				2a. DATE OF DEATH Month Day Year Aug. 17 1968		2b. HOUR 1:55 PM	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH Nov. 2, 1875		6. AGE (In years lost birthday) 92 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH GERMAN TOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MARYLAND HOME OF REST		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE DC MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1026 16th St. N.W.		14. FATHER'S NAME First Middle Last Alexander Keene Phillips		15. MOTHER'S MAIDEN NAME First Middle Last Annie Douglass Rogers		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? NO	
16b. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. Alexander K. Phillips, 2834 Brock Dr. Falls Church, Va.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobar, bilateral 490X DUE TO, OR AS A CONSEQUENCE OF (b) Bronch. tis 7days DUE TO, OR AS A CONSEQUENCE OF (c) - PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Arteriosclerotic C.V. Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 7 days	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED: While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9 Jan, 1965, to 17 Aug, 1968, that (I) (the) last saw the deceased alive on 16 Aug 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.							
22b. SIGNATURE Gordon Murdoch Smith MD				22c. DATE SIGNED 17 Aug 68		22d. PHYSICIAN'S NAME (Type) Gordon Murdoch Smith	
22e. ADDRESS Barnesville, Md 20703				23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
23b. DATE Aug 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.		24. FUNERAL DIRECTOR JOS. GAWLER'S SON'S INC. WASHINGTON, D.C.	
25a. REC'D BY REGISTRAR DATE AUG 21 1968				25b. REGISTRAR'S SIGNATURE Charles Yunge			

The first part of the report  
 is a description of the  
 work done during the  
 period from 1st January  
 to 31st December 1955.  
 It is divided into two  
 main sections: a  
 description of the  
 work done during the  
 period from 1st January  
 to 31st December 1955.  
 and a description of the  
 work done during the  
 period from 1st January  
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The second part of the report  
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